Review and Comparison of Four In-Home Service Programs

Department of Health & Mental Hygiene: Medical Assistance Personal Care

Department of Human Resources: In-Home Aide Services

Inter-agency Council on Aging Services (Office on Aging): Gateway II

Maryland State Department of Education: Attendant Care

State of Maryland

Department of Budget & Fiscal Planning

Division of Management Analysis & Audits

September 1984

Preface

Data collection for this study was undertaken from mid January to early April, 1984. The report reflects the situation as it existed at that time.

Acknowledgement

We wish to acknowledge and note our appreciation for the cooperation and assistance provided by the staff of the four agencies involved in this report.

Acronyms

AAA - Area Agency on Aging

CHC - Community Homemaker Chore

DHMH - Department of Health and Mental Hygiene

DHR - Department of Human Resources

DSS - Department of Social Services (local offices)

HHA - Home Health Agency

HMS - Homemaker Chore Services

IAC - Inter-agency Council on Aging Services

IHAS - In-Home Aide Services

MMAPC - Maryland Medical Assistance Personal Care

MSDE - Maryland State Department of Education

OoA - Office on Aging

SSA - Social Services Administration (State Office)

SSTA - Social Services to Adults

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EXECUTIVE SUMMARY

I. Introduction

This study was undertaken at the request of the General Assembly. The purpose of the study was to review, compare and contrast four State in-home service programs, determine whether maximum use is being made of Federal funds and to suggest alternatives, as appropriate, for administrative restructuring. The report includes a detailed discussion of each of the four programs followed by a highlight of the various interrelationships between these programs. Presented below are the specific recommendations for each program, along with some policy alternatives for consideration.

II. Department of Health and Mental Hygiene: Medical Assistance Personal Care Program (MMAPC)

MMAPC is a half-State, half-Federal funded program which provides primarily personal care services* to Medical Assistance clients in their own home. Services are provided by individual contractual care providers and contractual registered nurse case managers. The program has experienced significant growth since its inception in April of 1981, and now serves approximately 1,300 persons. In excess of 60% of MMAPC clients are age 65 or older.

There have been ongoing problems with the recruitment, enrollment and retention of sufficient numbers of good care providers. It is recommended that MMAPC staff implement a process for documenting those instances where eligible persons are turned away, served through other State or local programs, or must wait longer than 30 days to receive personal care services, because of insufficient

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* All service terms are defined on page 3.

numbers of care providers. It is also recommended that program staff develop a formal strategy for future care provider recruitment efforts. This report includes detailed suggestions as to how this might be approached. Once a care provider recruitment strategy has been developed, sufficient staff resources must be allocated to implement the strategy. Program expansion efforts cannot be fully successful if there are problems in meeting current demand for services.

With respect to problems with timely enrollment of care providers it is recommended that the application process be decentralized when appropriate.

The most significant and often mentioned problem with the MMAPC program was that of slow and irregular payments to care providers. DHMH staff are cognizant of payment problems and have begun to explore alternatives to address the problem. In our view, however, these efforts have not been adequate. It appears that payment problems are attributable to provider invoice errors and, perhaps, to inherent problems or inefficiencies in the State's payment processing system. The report includes a number of detailed suggestions as to how care provider problems with invoice errors may be addressed. With respect to inherent problems in the State processing system, it is recommended that DHMH selectively contact several of the care providers who have experienced or are experiencing significant non-error related payment irregularities. Specific problem invoices should be traced (or retraced) through the payment process to identify problem areas, the extent of such problems, and what actions will be necessary to alleviate such problems.

Reimbursement of travel expenses for care providers should be considered, especially in rural areas where the travel expenses are greatest.

There is no regularly scheduled formal training being provided by DHMH for MMAPC care providers. Formal training that would help insure a basic understanding of both the program and the skills necessary to provide services is recommended.

Given decentralization of record keeping responsibilities, it is recommended that basic program controls, such as random case manager record audits, be implemented.

There have been inter-agency problems with respect to the MMAPC program providing personal care services to Sheltered Housing residents. Some specific suggestions as to how this issue could be resolved are offered. The Inter-agency Council on Aging Services (IAC) would be an appropriate forum in which to address this issue and we recommend that they review and resolve the issue of personal and related care services for Sheltered Housing residents.

III. Department of Human Resources:In-Home Aide Services Program (IHAS)

The IHAS program is funded with both General Funds and Social Service Block Grant funds. It consists of two program components (one of which is restricted to persons 65 and older), both of which provide personal care and homemaker/chore services to eligible client populations. Services, in most instances, are provided by DHR staff aides and case workers; however, some services are purchased from the private sector.

The IHAS caseload has declined substantially in recent years, primarily due to budget reductions. Average monthly caseloads for this program are approximately 3,500. Aged clients have remained fairly constant at between 64% and 69% of total caseload.

Current IHAS regulations do not reflect agency practices and need substantial revision. We note that SSA's program structure is being reorganized.

SSA has developed a ranking scale for IHAS which addresses the fundamental issue of who receives services and who does not. We recommend that this be implemented statewide as soon as possible.

Interviews in eight jurisdictions suggest that local DSS administrators have responded to the problem of excess service demand by diluting the quantity and type of services provided. There is a basic policy question here as to whether public resources should be focused on those few most at need or, conversely, whether an attempt should be made to only partially meet the needs of a larger group. It is recommended that DHR management and perhaps the IAC consider further analysis on this issue and policy directives if deemed appropriate.

There is some variability from county to county in the types of in-home services offered by local DSS offices. It is recommended that DHR consider mandating, either through regulation or directive, that local DSS offices have available a minimum, "core" component of in-home services. Included among these services should be personal care, homemaker/chore services and perhaps respite care. It is our view that respite care could be part of a viable strategy to support and prolong the participation of families who wish to care for frail or disabled family members, but who do, on occasion, require some respite.

There is no formal need based methodology for allocation of case managers to local DSS offices. Some jurisdictions have been able to provide case management for all IHAS clients while others have not. SSA is reportedly going to begin a major study on allocation of SSA resources to local departments in the near future. It is recommended that this study be structured so that it addresses the issue of allocation of case managers for in-home aide clients.

IV. IAC - Office on Aging:

Gateway II Program

Gateway II is a General Funded program for those age 65 and over. It is currently operating in eight counties and Baltimore City. The program provides client assessment and evaluation, case management and a pool of "gap-filling" funds for the purchase of services. Services are procured primarily from the private sector.

First year data on the Gateway II program indicates that 448 of 1,118 clients received "gap-filling" funds for the purchase of services. The remainder of the caseload received case management services only. The data suggests that the Gateway II program is serving a functionally disabled population which is, in large part, eligible for nursing home care.

While the Office on Aging has established broad financial eligibility criteria for gap-filling clients, there is no standardized methodology or formula established for determining eligibility. This has resulted in considerable variability among the nine Gateway II counties. It is recommended that the methodology for determining financial eligibility for the use of gap-filling funds be standardized and a formula developed. Specifically, assets and income should be treated consistently throughout all jurisdictions. Simplicity, which appears to be lacking in some of the current methodologies, should likewise be a goal. Clearly any methodology developed should target those least able to pay.

Gateway II funds are awarded to local jurisdictions primarily on the basis of what is being requested. When need is considered, some jurisdictions may be, relative to others receiving funds, over-funded and some under-funded. A more structured and rational basis for fund allocations is needed. It is recommended that a formal mechanism be developed, subject to Executive and Legislative review, for the allocation of Gateway II funds. This mechanism should give considerable weight, to the extent that it can be measured, to the actual need of the disabled and poor elderly in each jurisdiction. Other factors, such as the administrative capacity of a jurisdiction to administer the program and the overall quality of the proposal should be considered, but given less weight than the need factor. It is also recommended that the allocation methodology for Gateway II take into consideration DSS allocations for in-home aide services in each jurisdiction to insure optimal utilization of in-home resources. It is imperative that a sound basis

for fund allocations be established as soon as possible. Local jurisdictions tend to become dependent on given funding levels and abrupt changes in these funding levels can adversely impact services to clients and create difficult administrative problems.

Data indicates that in excess of 80% of the gap-filling funds were used to purchase services that are the mandated responsibility of SSA and, to a less extent, the Medical Assistance Personal Care program. If SSA's IHAS program had greater resources, the large expenditure of Gateway II gap-filling funds for services normally provided by the IHAS program might not have been necessary. Similarly, had the Medical Assistance Personal Care program been more successful in recruiting and retaining care providers, purchase of personal care services for a small group of Medical Assistance eligible clients may not have been necessary.

Clearly a strategy of some of the local Gateway II programs is family grants. Both the MMAPC, IHAS and Attendant Care programs specifically prohibit the payment of public funds to family members. Payments to and through families to maintain a person in the community is a policy issue that would, in the interest of creating consistent State policy, be appropriate for further analysis by the respective service delivery agencies, the IAC and the General Assembly

Only 10% of all Gateway II funds have been allocated for administrative costs. This means that assessment and evaluation services, case management, administrative support and program management functions are almost totally donated, i.e., provided on an "in-kind" basis, by the three participating public agencies (i.e., Social Services Administration, Department of Health and Mental Hygiene and Area Agencies on Aging). In-kind contributions to Gateway II were in excess of $1.7 million for FY 1984. The Gateway II appropriation does not, therefore, reflect the actual cost of the program. This commitment of donated in-kind staff, all of whom have, or did have, other non-Gateway II duties and

responsibilities, may strain the resources of participating agencies. This strain occurs if existing programs are at capacity and the Gateway II work load represents additional persons being served. The in-kind donation which was agreed to by all participating agencies, may thus have adverse service implications for non-Gateway II clients. Furthermore in-kind donations result in a dual reporting relationship for those donated staff. All of the original Gateway II counties note the strain placed on participating agencies as a result of in-kind donations required by the Gateway II program. It is problematic whether agencies, with increasing pressures to provide services despite declining or static funding levels, will be willing and able to continue to make substantial uncompensated commitments of staff and resources to Gateway II. It may well be that use of in-kind services for major program functions may not be a viable long-term strategy.

Very little data is available on those 60% of Gateway II clients who are case managed only. Further information on the financial status and service needs of this group is needed to better evaluate the true impact of Gateway II.

The Gateway II program in Baltimore City uses the currently federally funded administrative structure of the Channeling program. These federal funds are to expire in FY 1985. There are several significant differences between the Gateway II model and the Channeling program. We recommend that the State Office on Aging, in conjunction with appropriate local officials, develop a plan that addresses these differences, some of which relate directly to the use of in-kind staff and which have considerable fiscal impact. Among issues that need to be addressed is the refocusing of the Channeling program toward improving inter-agency coordination in the City. Reportedly, a plan addressing these issues has been submitted to the federal Department of Health and Human Services for review.

V. Maryland State Department of Education: Attendant Care Program

This program is serving approximately 20 clients and is in its second year of a three year pilot project. It provides financial assistance to eligible disabled individuals who procure their own attendant care services and are then reimbursed, for a portion of the cost, with General Funds. This enables them to seek and hold employment and/or be deinstitutionalized.

The program has been significantly under-expended in its first two years of operation.

Some significant contrasts between this program and the other programs discussed in this report are presented as well as a number of issues that should be considered during the third year evaluation of this program.

VI. Other Issues

A. Comparative Costs

It would be useful for the IAC, as a long range goal, to begin to develop the data base necessary to do meaningful cost analysis of providing services to the elderly. Such information would be useful in making decisions on budgetary allocations and help insure that funds are optimally utilized. Reportedly, an ad hoc committee has been established to develop an inter-agency data base.

B. Maximizing Federal Funds

Two opportunities for increasing federal funds for in-home services are identified. First, local Area Agencies on Aging are decreasing both the percentage of federal Title IIIB Older Americans Act funds as well as the actual dollar amounts that they allocate to in-home services. Specifically, in FY 1981 AAA's allocated 11% of Title IIIB funds to in-home services; in FY 1984 only 5% were so allocated. The OoA has responsibility for approving all AAA budgets and has awarded waivers to seven local AAA's in FY 1984. These waivers release the AAA's from funding in-

home services. This is occurring at the same time that General Funds for Gateway II, which are being used primarily for in-home services, are being requested by the OoA. Significant reductions in Title IIIB funding effort by local AAA's in several jurisdictions after the implementation of the Gateway II program are noted. It is recommended that the OoA policy on in-home services be reviewed once again by that agency and perhaps the IAC with a view toward a more stringent policy on area agency in-home services waivers and reductions of effort.

A second way in which more federal dollars can be obtained is by better coordination of the MMAPC and IHAS personal care services. A review of IHAS clients in Baltimore City found 73 who could have been served by the 50% federal reimbursed MMAPC program. It is recommended that SSA issue a directive and implement appropriate procedures at local DSS offices to assure proper coordination between the two programs. Additionally, periodic reviews of the IHAS caseloads to assess whether MA eligible clients are receiving personal care service from IHAS is recommended.

C. Medical Assistance Home and Community Health Care Waiver

The report discusses a waiver and outlines some of the specific issues that need to be analyzed before applying for a waiver. It is recommended that prior to the submission of a waiver application, it be reviewed by the IAC. The client populations served by DHR and OoA are closely interweaved with the potential waiver population and possibly structural changes within the IHAS and Gateway II programs would be necessary if a waiver were implemented. We caution, however, against viewing the waiver as an immediate panacea to the State's long-term care needs, or more importantly, as a substitute program for the IHAS, Gateway II and Attendant Care program populations. In fact, given current federally imposed waiver requirements, it becomes problematic whether a waiver represents a realistic and cost-effective policy alternative.

D. Targeting Those At Risk of Institutionalization

Available data on community programs is not conclusive as to the impact that community programs actually have on institutionalization rates. The effectiveness of community programs in reducing rates of institutionalization would appear to be dependent on the ability to target services not only to the eligible needy but, more importantly, to those eligible needy who would have actually been users of institutional care in the absence of community alternatives. It is recommended that the IAC review current in-home service programs to assess whether resources are being focused on those most at risk of institutionalization. The MMAPC, IHAS and Gateway II programs are not specifically focusing on those persons applying for a level of care determination from the State's utilization control agent. These persons indeed are truly "at risk" of institutionalization in the immediate to near future. A formal program that provides counseling and information to these applicants and their families on community-based alternatives to institutional care should be explored by the IAC.

E. Inter-agency Council on Aging Services (IAC)

In our view administering the Gateway II program, which is an IAC project, has reduced the time that OoA's Long-Term Care unit has been able to devote to the many and complex problems facing the IAC. Refocusing some of this unit's resources from Gateway II to analysis of other key planning and funding issues might be appropriate and very beneficial to the service "system" over time.

VII. Policy Alternatives and Program Interrelationships

With respect to the Attendant Care program, we note that since it is in the second year of a three year pilot period, any major restructuring of the program would be premature at this point. If this program is continued, it can be structured to serve a specific adult disabled population in a unique way, and not be duplicative

of other State programs. This targeting, however, should not preclude consideration of transferring administrative responsibility for this program to another public service agency. This is an issue which will require further analysis and should be considered during the evaluation process.

With respect to the MMAPC program, we note that when functioning as designed and if properly coordinated with the other in-home service programs, there need not be any duplications or service gaps. MMAPC should be the first alternative considered for those Medical Assistance eligibles (i.e. those who are financially and medically eligible) who are in need of personal care services, with IHAS providing personal care only to those who are not eligible for MMAPC.

With respect to IHAS services to the elderly we note significant interrelationships with Gateway II. Both programs are providing many of the same services to much the same elderly population. For the Gateway II case managed only clients (about 60% of the total caseload) the true impact of the program is difficult to determine. For that 40% of Gateway II clients who are receiving gap-filling services, Gateway II appears to be functioning in large part as an additional service program. In effect, these gap-filling funds have been used to create an additional "program" of services for the frail elderly. A frail elderly person in a Gateway II jurisdiction can access services through the traditional (e.g., DHMH, SSA) service programs or through the Gateway II "system" which, while often using the traditional service delivery agencies, is different. The Gateway II gap-filling program does provide a range, quantity and intensity of service that, for a variety of reasons, has not been available through the traditional public service agency programs.

The Gateway II program is not without problems. These problems stem in part from the fact that the Gateway II program depends heavily on the donation of staff from DHMH, SSA and local AAA's. Gateway II has created an additional and

separate administrative structure complete with its own fiscal and program reporting requirements, its own State level administrative staff (in the OoA), and its own local program staff - albeit budgeted primarily in other agencies. Additionally, the respective missions of participating agencies and accountability for performance is somewhat obfuscated by this second system. Put simply the question becomes: Is the State going to concentrate resources in the traditional service delivery agencies (DHMH and SSA) and place responsibility for adequate in-home services to the elderly in those agencies? Or, conversely, will the State continue the practice of funding these same traditional in-home services (e.g., personal care, chore, etc.) through Gateway II as well? It could be argued that as long as Gateway II is given the resources to purchase traditional in-home services, there will be less money available and less incentive for the other service agencies to provide adequate in-home services for the elderly through their own programs. Indeed, if Gateway II is perceived as a provider of traditional in-home services, the "gaps" in existing programs could grow.

A related issue that needs to be addressed is the most appropriate and productive role for the Office on Aging. Should it be to continue administration of a service delivery program or should it concentrate on planning, coordinating, advocacy and administration of the Older Americans Act? In sum, the policy issue to be addressed is whether the needs of the frail elderly at risk of institutionalization should be accomplished: (1) through a continuation of the present Gateway II program and its gap-filling mechanisms, (2) through revitalized and adequately funded programs in the established service provider agencies, or (3) some combination of the two.

Another policy issue that needs to be addressed is what level of service the State should be providing to clients with long-term care needs. Gateway II provides a level of services to clients that is greater than that provided to elderly IHAS

clients. Whether the Gateway II approach is more effective than the IHAS approach in reducing or delaying institutionalization is unknown. The simple answer to "how much service is adequate" is that services should be sufficient to maintain those in the community who can reasonably be maintained in the community. Operationalizing this, however, is very difficult given the many variables that determine nursing home placements. Nonetheless, State policy makers must consider this issue in their deliberations on how the State is going to address long-term care needs.

The report presents four options as to how these issues that have been identified can be approached with a discussion of the advantages and disadvantages of each. In our view it is important that the State continue with the concept of developing coordinated long-term systems of care that treat clients in a systematic manner (i.e., assessment, evaluation, comprehensive case management and adequate services). Administratively this concept can be achieved in a number of different ways as the options presented suggest. Basically these options are: (1) maintenance of the status quo; (2) expansion of Gateway II; (3) increased funding of In-Home services in SSA while maintaining the Gateway II process and concept, albeit with fewer gap-filling dollars appropriated; or (4) concentrating resources and implementing the Gateway II program and concept through DSS.

All of the options presented emphasize services to those over 65 and provide special services to that group. State policy makers have with passage of Gateway II and CHC programs indicated that they want programs which include age as a criteria. Clearly it is this group that requires the great majority of in-home resources. Nonetheless, there is a population under the age of 65 which is at risk of inappropriate institutionalization and in need of services. Development of a long-term care system for all who require such services, regardless of age, is necessary.

I. INTRODUCTION

This report was requested by members of the General Assembly.

A. Purpose and Scope

The purpose of this study is to provide an overview and assessment of selected State in-home service programs. The programs included in this study are: Medical Assistance Personal Care, Department of Health and Mental Hygiene; In-Home Aide Services, Department of Human Resources; Gateway II, Inter-agency Council on Aging Services (administered by the Office on Aging); and Attendant Care, Maryland State Department of Education.

B. Objectives

The specific objectives of this study are as follows:

1. Compare and contrast the four programs with respect to:
   - Major goals and objectives
   - Eligibility requirements
   - Clientele served
   - Services provided
   - Administrative structure
   - Service delivery mechanisms
   - Funding mechanisms
   - Program costs
   - Planning and evaluation process
2. Review interrelationships between programs and in particular:
   - Review inter-program planning and coordinative mechanisms
   - Determine whether service duplications, overlaps or gaps exist
3. Determine whether maximum use is being made of federal funds.

4. Suggest alternatives, as appropriate, to optimize services at the most reasonable cost.

C. Methodology

Data collection for this study was undertaken January through April, 1984. A total of 68 persons were interviewed. These included State officials in DHMH, DHR, MSDE and the OoA. Local staff in eight jurisdictions throughout the State were also interviewed, with special attention being focused on the four original Gateway II sites (i.e., Talbot, Washington, Harford and Montgomery counties). Those interviewed included staff for local Departments of Social Services, Health Departments and Area Agencies on Aging. Additionally, several private service providers under contract with the State were interviewed. Numerous statutes, regulations, reports and memoranda pertinent to this study were also reviewed.

D. Report Format

Chapters II through V of this report discuss each of the four service programs. These discussions concentrate on issues specific to each program as well as the interrelationships between programs. Chapter VI discusses some basic issues which are pertinent to more than one program. The final chapter provides a broader systems' perspective and identifies some policy alternatives.

Table 1 presents some terms and definitions which are essential to understanding the discussion that follows.

Table 1

Definitions

Assessment/Evaluation - A face-to-face comprehensive interview with a client covering the multiple dimensions of health, i.e., biological, psychological and social. A comprehensive assessment includes the identification and evaluation of the long-term care needs of the client and is recorded on a standardized form.

Case Management - Case management follows a comprehensive assessment and includes all of the following components: care planning, arrangement and securing of all needed services, client follow-up and ongoing monitoring, regularly scheduled and "event-based" reassessment, and client tracking. Case management is an ongoing process whereby a worker identifies and secures the most appropriate services to meet the long-term care needs of a disabled client.

Chore Services - Services which maintain a safe, clean and healthy environment, e.g., cleaning a client's bedroom, bath and kitchen; personal laundry (bed linens, towels, gowns, clothing); meal preparation; financial management, shopping, picking up prescriptions, etc.

Heavy Chore Services - Services which address the performance of heavy household tasks such as cleaning walls, machine scrubbing floors, and removing large amounts of garbage and trash from the client's home and yard and structural and maintenance repairs.

Personal Care Services - Services which assist with the bodily activities of daily living which an individual would normally provide for himself, i.e., those that address bodily hygiene, nutrition, elimination and rest.

Personal Care/Chore - A service which offers both personal care and chore services as defined above through the same worker.

II. DEPARTMENT OF HEALTH AND MENTAL HYGIENE: MEDICAL ASSISTANCE PERSONAL CARE PROGRAM

A. Overview

Personal care is an optional service program authorized under Title XIX, Section 1905 (a) (17), of the federal Social Security Act. Maryland is one of 19 states that have chosen to include a personal care program in their Medical Assistance Plan. The Maryland Medical Assistance Personal Care (MMAPC) program is administered by the Division of Long Term Care under the Assistant Secretary of Medical Care Programs in the Department of Health and Mental Hygiene (DHMH).

The MMAPC program is designed to prevent the unnecessary or inappropriate institutionalization, at public cost, of long term, chronically ill or disabled persons. The program provides in-home personal care services designed to provide a maintenance or supportive level of care that will enable clients to continue residing in the community. These in-home personal care services generally offer a more cost-effective care alternative, from a public cost point of view, than institutionalization.

Defined broadly, personal care services are those services which "take care of the body." The actual type and amount of personal care services a client receives will vary, depending upon specific needs and requirements. Personal care services may include:

- assistance with personal hygiene and grooming (e.g., oral and denture care, bathing, shaving, and care of skin, nails and hair);
- assistance with activities of daily living (e.g., toileting, dressing, mobility, self-administered medications, nutritional planning, preparation of meals and eating);
- performing household services directly related to medical need and essential to a recipient's health and comfort in the house (e.g., changing bed linens, doing a recipient's personal laundry, rearranging furniture to enable a recipient to move about easier,

maintenance of kitchen area if food preparation is necessary, and straightening areas used by by recipient such as bathroom and bedroom);

- taking vital signs;
- shopping for groceries or items required specifically for the health and maintenance of the recipient; and
- transportation/escort services to assist recipients to medical treatments.

The MMAPC program has experienced a fairly significant rate of growth since its inception in April of 1981, which is reflected in Table 2. Approximately 1,300 Medical Assistance clients are currently receiving services through MMAPC. It is estimated that in excess of 60% of these clients are age 65 or older, and an estimated 40% of the clients are nursing home eligible according to Medical Assistance utilization control standards. The MMAPC has been serving in large part, those individuals who are six to nine months away from nursing home eligibility, as opposed to those persons who are in immediate need of nursing home care. It is noted however that the program has not specifically targeted any population over another.

Table 2

MMAPC Active Caseloads

Date	Number of Active Cases	Growth over Prior Year
January 1982	283	-
January 1983	633	124%
January 1984	1271	101%

Source: Division of Long Term Care, Department of Health and Mental Hygiene

B. Program Eligibility and Funding

Medical Assistance eligibility is established through the State's local Social Service Departments. There are two ways a recipient can qualify for Medical Assistance: (1) as categorically indigent or (2) as medically indigent. The

categorically indigent are those persons who are eligible to receive cash payments under the Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI)*, and General Public Assistance (GPA) programs. The medically indigent are those persons whose income and resources are sufficient to pay for basic living expenses, but are not adequate to meet the cost of necessary health care. Medical Assistance eligibility for the medically indigent, as shown in Table 3, is based upon the number of persons in the family unit and the family's assets and net income (gross income less certain deductions and exclusions). For example, a single person would qualify as medically indigent if his annual net income does not exceed $3,200 ($267 per month) and if his assets do not exceed $2,500.

Table 3
Medical Assistance Eligibility

Categorically Indigent	Medically Indigent		
	Family Size	Net Income Standards(1)	Assets Standards
AFDC recipient SSI recipient GPA recipient	1	$3,200	$2,500
	2	3,700	2,600
	3	4,200	2,700
	4	4,700	2,800
	5	5,200	2,900
	6	5,700	3,000
	7	6,200	3,100
	8	6,700	3,200

Note: (1) These net income eligibility standards have increased approximately $300 annually effective July 1, 1984.

Source: Division of Eligibility Services, Medical Assistance Policy Administration, Department of Health and Mental Hygiene

* Eligibility for SSI is established through the federal Social Security Administration with actual determinations being made through the Division of Vocational Rehabilitation in the Maryland State Department of Education.

Federal matching funds are available (on a dollar for dollar match) to pay for personal care services provided to the categorically indigent who are AFDC or SSI recipients. Federal matching funds are also available to pay for personal care services provided to the medically indigent who are blind, disabled, aged, younger than 21, or classified as caretaker relatives. For the categorically indigent who are GPA recipients and the medically indigent who are between the ages of 21 and 65 and who are not blind or disabled, federal matching funds are not available; General Funds are used to provide personal care for these people. Since most MMAPC recipients are in federally matched categories, program expenditures are funded in roughly equal proportions with federal and General Funds. Total annual purchase of service expenditures for MMAPC, shown in Table 4, are approaching $3 million.

Table 4

MMAPC Purchase of Service Expenditures*

Fiscal Year	Expenditure
1981 (Actual)	$ 57,173
1982 (Actual)	568,564
1983 (Estimated)	1,455,000
1984 (Estimated)	2,763,000
1985 Appropriation	2,958,012

Source: Division of Management and Fiscal Services, Department of Health and Mental Hygiene

* Expenditures include only purchase of service costs; direct and indirect program administrative costs are not included.

C. Program Operations

There are four basic components in the MMAPC program: administrative staff, case managers, care providers and clients. While program administration is handled by a small staff unit at the State level, service delivery is effected through a decentralized system of independent contractual case managers and care providers. The narrative that follows discusses each of the four program components.

Administrative Support Staff

Program support and administrative oversight is provided by a three person staff unit, located in Baltimore and reporting to the Director of Long Term Care. The unit consists of a Nurse, an Administrative Specialist Trainee, and a Section Head position which is currently vacant. The major responsibilities of this unit include: recruiting, enrolling, training, and maintaining a register of case managers and care providers; approving care plans and authorizing start of care for each client; and maintaining program statistics. Record keeping functions, initially centralized with this unit, have been largely decentralized to the case manager level.

Case Manager

Federal regulations require that the provision of Medical Assistance personal care services be supervised by a licensed registered nurse. This nursing supervision is obtained on a contractual basis. As can be seen in Table 5, DHMH currently has contractual agreements for personal care case management services with several individual registered nurses, a variety of private profit and non-profit health care organizations, and some of the local Health and Social Service departments. Each jurisdiction in the State has at least one case manager or case management agency. Private profit and non-profit case

management agencies are the most prevalent. Local Health and Social Service departments tend to participate in the MMAPC program in jurisdictions where few, if any, alternate case managers are available, or are willing, to participate. Urban areas generally have a greater availability of case management services.

Table 5

Case Management Services by County

	Individual R. N.	Private Profit and Non Profit Organizations*	Local Health Dept.	Local Social Service Depts.
County	-	-	1	-
Anne Arundel County	3	4	1	-
Baltimore City	8	8	-	-
Baltimore County	3	6	-	-
Calvert County	-	2	-	-
Caroline County	-	-	-	1
Carroll County	-	1	1	-
Cecil County	-	2	-	-
Charles County	-	-	1	-
Dorchester County	-	-	1	-
Frederick County	-	1	-	1
Garrett County	-	-	1	-
Harford County	1	3	-	-
Howard County	-	5	-	-
Kent County	-	1	1	-
Montgomery County	-	6	-	-
Prince Georges County	-	7	-	-
Queen Annes	-	1	1	-
St. Marys	1	-	-	-
Sommerset	2	-	-	-
Talbot	-	1	-	-
Washington	-	1	1	-
Wicomico	3	-	-	-
Worcester	2	-	-	-

Source: Division of Long-term Care, Department of Health and Mental Hygiene

* Organizations frequently have more than one R. N. available for case management. Additionally, some organizations service more than one jurisdiction and are reflected, therefore, as duplicate counts in the table.

Case management, as provided through MMAPC, is not the comprehensive service brokerage type of case management that addresses a variety of needs and is typically associated with Social Service Department social workers. Rather, MMAPC case management is focused solely on those services provided to recipients through the MMAPC program. Under the terms of their contractual agreement, case managers are responsible for the following services:

- a home visit to assess or reassess client need for care;
- consulting with the client's physician;
- developing a written plan of care;
- assisting the client in locating a personal care provider and instructing that provider concerning services required under the plan of care;
- making home visits at least every 60 days to assess the plan of care, the provider's performance, and the need for the client's discharge from MMAPC or referral to other services;
- documenting care and services provided, keeping records, and submitting reports as required by the department; and
- being available to give instruction and answer questions during the normal working day.

In order to insure that basic client needs which extend beyond the capabilities of the MMAPC program are met, it is recommended that case managers be periodically provided basic information on services available in the community through local Area Agencies on Aging and Departments of Social Services and Health.

Case managers are compensated at the rate of $35 per month for each recipient they supervise. This rate will be increased to $37 per client-month in FY 1985. Each case manager can carry a caseload of up to 50 active cases, although DHMH may authorize additional cases under certain circumstances.

Care Providers

There are no licensing requirements for a personal care provider; however, providers must meet certain minimal requirements. Specifically, providers must be able to read, write, follow instructions, understand and carry out a plan of care. Care providers must also pass a physical examination. Furthermore, they must be acceptable to the client. Providers cannot however, be a member of the client's family.

Care providers, like case managers, are independent contractual workers. They work under a Personal Care Agreement which is a three way contract between DHMH, the client, and the care provider. Care providers are restricted to two active cases at a time, unless authorization for additional cases is obtained from DHMH. Providers are reimbursed at the rate of $10 per client for each day of personal care provided, regardless of the actual time spent in providing such care. Providers are responsible for keeping records containing the case manager's instructions, the days and times worked, tasks performed, and progress notes.

Clients

To be eligible for the MMAPC program, an individual must:

- be financially eligible for Medical Assistance;
- be under a physician's care for a chronic illness, medical condition, or physical or mental disability;*
- be determined by the department's standard assessment of functional capability to need assistance in performing personal self-care activities;
- be moderately at risk of institutionalization;

* Chronic illness, medical condition or disability means a physical or medical disability which is defined as a reasonably static impairment which prevents or impairs the accomplishment of normal activities of daily living and which requires ongoing medical supervision for an indefinite period of time.

- have a physician's orders for personal care; and
- reside at home.

To access the program, a potential client must contact an approved case manager. A list of approved case managers is maintained by the program staff unit and regularly disseminated to local Health and Social Service departments, hospitals, and other health organizations. It is social workers, hospital discharge planners, physicians and other health professionals who usually refer potential MMAPC clients to specific case managers. Sometimes families, neighbors or friends who have heard of the program will refer a potential client to the program.

Upon being contacted by a potential client, the case manager will do a preliminary screening over the phone to determine whether the individual requesting services appears to be eligible for MMAPC services, and if so, will schedule an in-home visit. During the in-home visit, the case manager will complete a standard assessment of functional capabilities which covers both the applicant's social and functional status. Together, the case manager and the applicant decide on an appropriate plan of care, including the necessary personal care services, their frequency and duration. A Personal Care Services Application and Plan Of Care is completed and signed by both the case manager and the applicant and is then sent to the applicant's physician who completes the medical information section, signs the form, and then forwards it to DHMH. The physician's approval and signature constitutes "physician's orders for personal care."

The application and plan of care are reviewed by the MMAPC program staff nurse for both eligibility and appropriateness of services. The nurse will then issue a "pre-authorization" for services which is valid for 30 days. During this 30 day period, the case manager must contact a care provider (unless the client has

a friend or neighbor who is willing to provide care) and schedule a meeting at the client's home. If the personal care arrangement is acceptable to both the client and the care provider, then the case manager will instruct the provider on the specific services required under the care plan. A Personal Care Services Agreement is signed by the provider and the client and then forwarded to DHMH for approval and authorization to start care.

In addition to receiving routine visits from the care provider, the client receives a visit from the case manager at least every 60 days. These visits serve as quality control checks on the care being provided and make possible periodic assessment of the client's condition. Complete reassessments are required annually for each recipient.

D. Program Issues

Interviews with MMAPC case managers and local Health and Social Service department personnel generally indicate a positive attitude toward the MMAPC program and its potential. However, several issues were raised during these interviews which may impair, and in some instances already have impaired, the effectiveness of the program. These issues are discussed below.

Care Provider Recruitment

Interviews indicate that ongoing problems exist with respect to the recruitment, enrollment and retention of good care providers. It is important to note that the success of the MMAPC program does, of course, depend heavily on having adequate numbers of care providers available to provide services to eligible clients.

At the program's onset, it was envisioned that friends and neighbors of the service recipients would be a major source of care providers. This source, however, did not prove entirely satisfactory. Reportedly, early in the program,

as many as half of the eligible clients could not be served due to a lack of care providers. Since that time, MMAPC staff has sought to recruit providers through community and church groups, press releases and government programs such as Work Incentive Demonstration (WIN)*.

Given the growth in program service levels, the availability of care providers has obviously improved somewhat since the program's inception. While these efforts show that MMAPC staff are aware of the importance of provider recruitment, to date, provider recruitment efforts have not been successful in generating adequate numbers of care providers. A program survey** of case managers completed in May of 1983 revealed that a large percentage of case managers (76% of those surveyed) were experiencing problems relative to the availability of adequate numbers of care providers. Some of the case managers even reported that they had ceased to process client applications for service due to the shortage of providers. Interviews conducted during this study indicate that these provider recruitment problems have not been resolved as yet.

Case managers and local Health and Social Service department staff report that there are still not adequate numbers of care providers available to service eligible clients. This problem was noted in each jurisdiction we reviewed, although the magnitude of the problem varied among jurisdictions. In jurisdictions where provider recruitment was a significant problem, it was addressed in a variety of ways. Some MMAPC case managers reported that,

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* The Work Incentive Demonstration (WIN) program, administered by the Department of Employment and Training, is designed to assist AFDC recipients find employment.

** Personal Care Program Survey of Case Managers, Division of Long-Term Care, Department of Health and Mental Hygiene, May 1983.

when providers are not available to service new applicants, generally applicants are placed on a waiting list until providers can be found. One case management agency reported that they had quit taking MMAPC applications in one urban jurisdiction because there were never care providers available. Case managers also noted that they had, upon occasion, terminated services to clients when care providers had quit and replacement providers could not be found. Several of the local Health and Social Service department personnel who reported experiencing problems with referrals to the MMAPC program because care providers were not available noted that, in such instances, MMAPC eligible clients are being served through other State or local programs (e.g., In-Home Aide Services, Gateway II, local health programs, etc.), either on an ongoing basis or until such time as an MMAPC care provider can be found.

Statistics are not being kept on the number of potential MMAPC clients who are being served through other state or local program initiatives or whose applications for MMAPC services are not even being processed. It is therefore difficult to adequately gauge the magnitude of the care provider recruitment problem. It is recommended that MMAPC staff implement a process for documenting those instances where eligible persons are turned away, served through other State or local programs, or must wait longer than 30 days to receive MMAPC services, because of insufficient numbers of care providers. This will help to identify the extent of the existing problem and should help gauge the level of staff effort necessary to devote towards recruiting efforts. It is also recommended that program staff develop a formal strategy for future recruitment initiatives. Some examples of possible strategies are:

1. Review past recruitment efforts to determine what approaches and which sources have been most successful in developing dependable providers.

2. Identify those jurisdictions where provider shortages are most severe. Determine the nature of the provider shortage problem, i.e., is it really a lack of available providers or is it a geographical problem? Target resources to those areas with the greatest problems.
3. Develop a creative targeting approach that would identify resources available in each jurisdiction and focus on those with the most potential. Some examples might be: college social worker programs, nurse training programs, or hospitals with aide staffs that might be willing to become involved in MMAPC care provider agreements; Senior Aide and Employment programs, Displaced Homemaker programs, etc; and non-profit service organizations who might be available as group providers.
4. Encourage case managers to recruit providers. Recruiting is being done by some case managers now. Case managers and case management agencies are locally based and, as such, often are involved in local activities or have close local contacts which would be conducive to provider recruitment. We would note that this strategy should not be relied upon as a sole recruitment strategy.
5. Encourage active care providers to recruit potential care providers from among their friends and acquaintances.
6. Expand the current caseload limit from two recipients per provider to four, subject to the discretion of the case manager. While this will not increase the number of available providers, it will increase the number of recipients who can readily be served.

7. Consider providing travel reimbursements in those jurisdictions where providers must travel excessive distances to recipient homes as is sometimes necessary in rural areas.

Once a provider recruitment strategy has been developed, sufficient staff resources must be allocated to implement the strategy. We believe this need can be met with appropriate use of existing program resources provided that all positions are filled. These provider recruitment efforts will become even more important if a waiver (discussed later in this report) is to be pursued. Program expansion efforts cannot be fully successful if there are problems in meeting current demand for services.

Provider Enrollment

The provider enrollment process was also frequently mentioned during interviews as being too slow and requiring considerable case manager time. When a potential provider is located by a case manager or suggested by a recipient, the potential provider is given a provider applicaton by the case manager. The application is completed and mailed to DHMH where it is processed by the program staff unit. The staff checks the listed references and then sends the approved application to the provider enrollment unit in the Medical Assistance Operations Administraiton (DHMH) where it is assigned a provider identification number. Once the approved application reaches the Operations Administration unit it reportedly requires only one day to complete the provider number assignment and enrollment process.

Case managers report that the provider approval and enrollment process frequently takes six weeks or longer, during which a client is going without needed services. In emergency cases, however, the program staff unit will authorize start of care prior to processing the paper work. Case managers report

that they often must make frequent calls to DHMH staff to determine if the provider applicant has been approved and a provider number issued.

In one jurisdiction, provider applications are being processed by the local case management agency, with references being checked and verified prior to the application being mailed to DHMH. This process has reportedly resulted in a much shorter processing time. It is recommended that responsibility for the provider application process, including reference checks, be decentralized for those applicants recruited by case managers or suggested by clients. It has been suggested by case managers that processing provider applications would require less of their time than is currently being spent in tracking down applications enmeshed in the State system. This decentralization of provider application processing should facilitate service start-ups and free up DHMH staff for other functions such as provider recruitment. Decentralization would not of course, preclude program staff from processing independently submitted provider applications or from performing periodic quality control reviews of case manager processed applications.

Payment Problems

The most significant and often mentioned problem with the MMAPC program was that of slow and irregular payments to providers. This problem was mentioned by every case manager interviewed. There were reported incidents of care providers who had worked for six months or more before ever receiving any payment, and providers who had received initial payments but then experienced delays of five to six months before receiving additional payments. There was one reported case of a provider being owed $1,500 in back payments. It is apparently not uncommon for providers to experience significant delays between payments. The problems that irregular payments create is magnified when one considers that (1) an estimated 65% or more of the providers depend upon MMAPC

payments as their primary or sole source of income, (2) providers are paid only $10.00 a visit and (3) providers are not reimbursed for any travel expenses, even when transporting clients to the grocery store or to visit a physician.

These payment irregularities not only impact upon the individual provider, but upon the client, the case manager, and the effectiveness of the program as well. Case managers report that they spend inordinate amounts of time on the telephone, with both providers who haven't received payments and with DHMH staff, trying to resolve payment problems. Case managers also report that the motivation of providers is sometimes adversely affected by slow and irregular payments, and that good care providers are leaving the program because of these payment problems. Furthermore, provider recruitment is reportedly becoming more difficult because of awarness of payment problems.

These payment problems are not new. A program survey* of care providers completed in June of 1983, noted that "with forty five (45%) percent of our active providers totally dependent on their personal care earnings it is imperative that we revise our reimbursement system so that providers receive payment in a timely and regular fashion, if we wish to keep them on the job." The survey of case managers, completed in May of 1983, also indicated the existence of significant provider payment problems.

In our view, efforts to address these payment irregularities have not been adequate. While DHMH staff is currently exploring various payment alternatives (as discussed later), care providers are being informed that they can not depend on regular or timely payments and that they should not depend on MMAPC

* Personal Care Program Survey of Direct Care Providers, Division of Long-Term Care, Department of Health and Mental Hygiene, June 1983

payments as their sole source of income. The fact is that many care providers do depend upon MMAPC payments as a sole or primary source of income and do therefore need to receive payments with some semblance of regularity. If program staff do not acknowledge this, provider recruitment and retention problems will continue and possibly threaten the program's ability to serve those clients it is mandated to serve.

As independent contractual workers, case managers and care providers must invoice the Medical Assistance Program for payment as do other Medical Assistance providers (e.g., hospitals, nursing homes, doctors, home health agencies, etc.). Providers and case managers use a special Home Health Invoice. The DHMH invoice processing unit places Home Health invoices third on the processing priority list, behind nursing homes and hospitals. It reportedly takes a properly completed invoice about 12 working days to be processed through DHMH and up to 7 more working days for a check to be prepared by the Treasurer's office and mailed. While this is a somewhat lengthy process even for error-free invoices (3 to 4 weeks), it appears that if invoices are properly filled out and submitted on a regular basis (e.g., every 2 weeks), payments should be forthcoming with some semblance of regularity (e.g., every 2 to 3 weeks).

One main reason for payment irregularity, according to DHMH staff, is incorrect or incomplete provider invoices. Incorrect invoices must be returned to the provider for correction and then resubmission, all of which contributes to payment delay. In the invoice batch we reviewed, 21% of the Home Health invoices were rejected by the computer because of errors. Some of these errors were staff keypunch errors and others were provider invoice errors. Keypunch errors are immediately recycled into the computer while invoices with provider errors are, as noted above, mailed back to the provider. Common provider

invoice errors include: illegible invoices, duplicate or advance billing, incorrect totalling of charges, invalid procedure code, and invalid provider or recipient numbers. The printout that we reviewed indicated that, at least for that particular run, duplicate billing was the reason for 86% of the invoice errors.

In discussing these provider invoice errors with case managers, we were told that provider errors are a part of the payment problem but that there are frequent occurrences where providers submit properly completed invoices and payment problems still persist. Case managers noted that payment irregularities are especially noticeable during holiday periods. Thus, it would appear that payment problems are attributable not only to provider errors, but perhaps to inherent problems or inefficiencies in the State's payment processing system as well. As a two-fold problem, solution of the payment issue will require a two-fold approach.

With respect to the problem of provider errors, some fairly simple steps might alleviate the majority of provider invoice errors. We note that currently case managers receive instruction on the invoice process and are, in turn, responsible for instructing care providers on how to properly complete an invoice. Providers are given a sample invoice for reference. Generally, providers are left with a pre-authorized and predated supply of invoices sufficient for a two week period, with the maximum authorized number of billing dates noted on each invoice. More attention should be given by case managers to instructing providers on the importance of keeping a duplicate copy of each invoice submitted and referencing prior invoices each time they prepare a new invoice. This should assist in alleviating errors such as duplicate billing dates, and incorrect service codes, client information, and provider numbers. Second, case managers could leave pre-completed invoices with providers so that the provider only has to check (or delete) dates they did (or did not) actually work,

total the charges and then sign their name. This would alleviate most provider errors with the exception of incorrect totalling of charges. This latter item could be corrected by DHMH staff without having to return the invoice to the provider. Another alternative would be to channel all provider invoices back through the case manager before submission to DHMH. This, theoretically, is the correct process but it apparently is not always being done. The case manager would serve as a quality control check by insuring that invoices are legible and properly completed. This review has been initiated by some case managers. One case manager reported that as a result of payment problems she has begun to collect, review and submit invoices for her care providers. She noted that it was too soon to tell if this process had been effective in resolving payment problems. Another case manager noted that she had been reviewing and sending in invoices for her providers (and thus knew they were being submitted without error) but that there were still problems with payment irregularites. This would reaffirm that the payment irregularity problem is, as previously stated, a result of more than just provider errors.

With respect to the problem of inefficiencies in the State processing system, further analysis will be required in order to clearly identify the exact nature of existing problems or inefficiencies. It is recommended that DHMH selectively contact several of the providers who have experienced or are experiencing significant non-error related payment irregularities. Specific problem invoices should be traced (or retraced) through the payment process to identify problem areas, the extent of such problems, and what actions will be necessary to alleviate such problems. For instance, if part of the problem is found to lie with timely approval of provider applications and assignment of provider numbers, then perhaps decentralizing responsibility for pre-processing provider applications (as discussed earlier) would alleviate excessive delays in processing

initial payments. Problems relative to payment irregularities will, of course, have to be addressed in other ways.

Recently, DHMH has begun exploring ways to facilitate provider payments. Some of the options under consideration include:

- front-end invoice screening, which would screen out incorrect invoices immediately but would delay payment of correct invoices for up to seven days, while not significantly facilitating payment of incorrectly submitted invoices;

- establishing a provider relations group to provide training to providers on how to properly complete invoices, and to be available to providers when problems arise; and

- issuance of working capital to case managers (as is currently done for nursing homes and hospitals to help with cash flow); this would however create potential for financial abuse and recovery problems, and probably require an increase in case management fees.

While these DHMH initiatives are a positive sign that the provider payment problems and their implications have been recognized, we would offer a few comments. As stated earlier, DHMH should first investigate and identify exactly where the payment problems lie before implementing any major changes. Obviously, provider error problems do exist and can be addressed fairly simply and without any major structural changes. System problems, however, should be first specifically identified, perhaps through an invoice audit as suggested earlier. If the solution to payment irregularity problems mandates a significant change in the payment process, such as the issuance of working capital, we would suggest that perhaps DHMH consider issuing working capital to only those nine jurisdictions where a local Health Department is involved in case management. In these jurisdictions the local department's MMAPC case manager could review, approve and pay provider invoices as they are received. The case manager would then submit to the State for care provider reimbursement on a monthly basis. This would provide for prompt payment to providers, would include a quality control measure, and would presumably simplify the payment/reimbursement

processing at the State level. The working capital outlay required to implement this strategy would not be significant when viewed in terms of working capital currently outstanding for hospitals and nursing homes. If this system proves successful, it could perhaps be expanded Statewide as a local Health Department function. This procedure would, of course, entail administrative costs. These additional costs should be viewed in the context of their overall impact on the effectiveness of the MMAPC program.

The issue of payment rates should also be noted. On July 1, 1983, the reimbursement rate for providers was increased, from $9 to $10 per day of personal care, in response to concerns about the payment rate. Program staff indicate there are plans to do a small audit of provider records to see how much time is actually being spent in providing services, and whether the $10 per day of care rate is adequate given the time being spent. We would encourage these efforts.

Finally, we wish to briefly note the issue of travel reimbursement for providers. Travel reimbursement especially in rural areas would greatly facilitate the case manager's ability to recruit providers for clients. Reimbursement should also be considered for providers who transport, at their own expense, clients to medical services.

Provider Training

Federal regulations require that a provider of personal care services be "qualified." The term "qualified" has not been defined and federal guidelines suggest that some criteria be developed. The guidelines further suggest that the criteria might include at least 40 hours of training in basic personal care procedures, first aid, care of the aged, etc.

While MMAPC regulations do provide for a $10 payment to providers for each day spent in approved training, there is no regularly scheduled formal

training being offered by DHMH for MMAPC care providers. Furthermore, care providers have not been required to receive any training other than the client-specific training they are supposed to receive from the case manager detailing the services to be provided under a client's specific plan of care.

Two of the case management agencies interviewed noted that their agencies did provide a basic training course for care providers they supervised. One of the agencies noted that these training sessions are an investment of time and resources for which they are not reimbursed, and which they might not continue to offer. Other case managers interviewed were unaware of any formal training received by or available to care providers. Several case managers noted the desirability of basic personal care training for providers.

DHMH has prepared an excellent personal care provider manual which introduces the MMAPC program, explains its philosophy, and details services commonly performed by care providers. The manual is not generally given to care providers, rather, the manual is made available to case managers who are responsible for making the information available to care providers. It is not at all clear that providers are benefiting from this manual. A structured training course for providers which uses this manual as a basic text would help to insure a basic understanding of both the program and the skills necessary to provide services and is recommended. These training sessions should be offered by DHMH program staff at regular intervals and preferably on a regional basis to insure easy access for providers. Attendance at a basic personal care training session should be mandatory for all providers.

Administrative Issues

As mentioned earlier, program record keeping functions have been largely decentralized. This decentralization occurred in July, 1983 due to the excessive amount of time required by DHMH program staff to process and file paperwork.

Case managers now have full responsibility for keeping complete client files. Given this decentralization of record keeping responsibility, it is recomended that basic program monitoring controls be implemented. An example would be 60-day case reviews. Case managers are required to provide 60-day case reviews for each recipient which includes a review of the care plan, the quality of care provider services, and the need for the client to continue in the program. It is noted that when DHMH program staff were receiving and monitoring 60-day reviews there were problems, particularly with case management agencies having large client caseloads, in having timely 60-day reviews completed. Now that the DHMH staff unit no longer monitors 60-day reviews, there is no assurance that the reviews are being conducted in a timely fashion. Random case manager record audits should be considered as a strategy for monitoring quality of care.

Annual client reassessments are still being monitored by DHMH program staff. At the present time, staff is going through all 1,300 client cards every six to eight weeks to determine who is due for an annual reassessment, and then notifying appropriate case managers. A separate tickler file system indexed by month might prove more efficient than the current process of reviewing all 1,300 client cards and is recommended.

Sheltered Housing

Sheltered Housing is a statutory responsibility of the Office on Aging (OoA). The OoA contracts with a variety of providers throughout the State for some 770 units of Sheltered Housing. A Sheltered Housing contract requires that certain basic services must be provided to residents including three meals each day of the week and a minimum of one hour per week each of personal care and housekeeping. These Sheltered Housing services are purchased with a combination of General Funds, federal Older Americans Act funds, and resident payments.

In the past, MMAPC has provided personal care services to Medical Assistance eligible Sheltered Housing residents. However, the current MMAPC policy is to not provide services to eligible Sheltered Housing residents because they are receiving personal care services as part of the Sheltered Housing arrangement. The Sheltered Housing contracts specify that the housing agent will provide "a minimum of one hour of personal care per week." According to OoA staff this minimal requirement was established because of funding limitations. Interviews with various State and local Aging, Health and Social Service department staff suggest that while this level of personal care services is sufficient for some of the Sheltered Housing residents, there are others who require more care than is being provided (generally residents are being provided only the minimum required care levels). In one county, the local DSS office reported that they were serving five Medical Assistance eligible Sheltered Housing residents through their In-Home Aide Service program. A Health Department official in another county stated that Sheltered Housing residents were doing without necessary levels of services. The purpose of Sheltered Housing, like each of the programs included in this study, is to provide a community alternative to institutionalization. Clearly, if the Sheltered Housing population is to remain in the community, adequate personal care and other related services must be provided.

There are a number of ways in which this issue could be addressed such as: (1) OoA limiting the number of Sheltered Housing units purchased to insure adequate levels of care can be provided to all Sheltered Housing residents, or (2) cooperative inter-agency agreements to meet service needs and fill service gaps. While there has been some correspondence between OoA and DHMH regarding a cooperative approach to addressing this issue, to date, the issue has not been resolved. The IAC would be an appropriate forum in which to address

this issue and we recommend that they review and resolve the issue of personal and related care services for Sheltered Housing residents. A formal Memorandum of Understanding between the service providing agencies, detailing their respective roles and responsibilities relative to the Sheltered Housing population and specific guidelines for effecting the agreement, might be an appropriate mechanism for addressing this issue.

Home Health Services

Home health services are mandated under Title XIX and must be included in the State's Medical Assistance Plan. Home health services are generally provided by public and private agencies and organizations known as Home Health Agencies (HHA). These services are similar to, but more skilled in nature than, the services provided through MMAPC.

Home health services include:

- Skilled nursing services provided by or under the supervision of a registered nurse;
- Home health aide services, which include personal and health care;
- Other services such as physical therapy, occupational therapy, and medical social services.

HHA services are available to Medical Assistance recipients who are homebound and under the care of a physician who orders the type, frequency and duration of home health services to be provided. A written plan of treatment is obtained from the physician and must be reviewed and updated every 60 days.

Ideally, HHA services should be used only when a client requires a more highly skilled level of care than MMAPC can provide or when the client's condition does not qualify for MMAPC (e.g., if the condition is not chronic). However, under current regulations there are some instances where personal care services and home health services overlap. For example, recipients who do not need skilled care services may receive non-skilled HHA home health aide

services if those services will delay or prevent institutionalization. Fees for home health aide services range from about $30 to $46 per visit. This is, of course, far more costly than the $10 per day payment to personal care providers under MMAPC. DHMH is in the process of promulgating new HHA regulations which should become effective in July, 1984. These new regulations more tightly define HHA services and requirements and distinguish more clearly the HHA role vis-a-vis the MMAPC role. The new regulations specifically exclude HHA from providing personal care services rendered to recipients with chronic conditions, when those recipients require none of the skilled HHA services or health care services rendered by an HHA home health aide and supervised bi-weekly by a registered nurse. These new regulations should reduce HHA and MMAPC program overlaps by precluding recipients who could effectively be served through MMAPC from being served, at greater cost, through an HHA.

III. DEPARTMENT OF HUMAN RESOURCES: IN-HOME AIDE SERVICES

A. Overview

The In-Home-Aide Service (IHAS) program is administered by the Social Services Administration (SSA) of the Department of Human Resources (DHR). Its purpose is to provide a system of community services which provide an alternative to inappropriate institutional care for incapacitated and dependent persons of all ages. To receive IHAS services, a client must contact the local Department of Social Services (DSS) office where social need and financial eligibility for services are assessed through the case management assessment process. A case plan detailing necessary services is then developed. Services are terminated when, according to DSS criteria, they are no longer appropriate.

B. Program Components

The IHAS program has two components, Community Home Care (CHC) and Homemaker Services (HMS). Article 88A, Sections 84-87, of the Annotated Code of Maryland established the CHC program to provide a comprehensive range of community services to those 65 or older. Administrative responsibility for CHC was placed with "the Department of Employment and Social Services* (to be provided) with the advice and cooperation of the Office on Aging and the Department of Health and Mental Hygiene." Services provided under CHC include case management services which are provided by a social worker and personal care, homemaker/chore, and transportation/escort services which are provided by aides.

The HMS program has no specific statutory mandate other than its annual budget appropriation. HMS services are not restricted to the elderly; however, a

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* Since changed to Department of Human Resources

majority of its clients are age 65 or older. Services available through HMS include case management and all of the aide services provided under CHC, as well as therapeutic aide services. Therapeutic aides provide emotional support and guidance to clients who may abuse, or neglect their children, adult dependents or themselves.

It should be noted that the Social Services Administration has reorganized its service delivery structure for adults. As a result of this reorganization case management/social work services in local Departments of Social Services are now provided through the Social Services to Adults (SSTA) program. In Home Services, both those provided through the CHC and HMS programs do not, in effect, function as separate and discrete programs. Nonetheless all current regulations and the budgetary program structure still refer to the CHC and HMS programs. We are therefore compelled for the purpose of this analysis to continue to discuss IHAS services in the context of the CHC and HMS programs.

C. Funding and Client Caseload

Funding for the IHAS program comes primarily from a combination of Social Services Block Grant funds and General Funds. A portion of the General Funds are actually appropriated to the Office on Aging and then transferred to SSA through the budget amendment process. In FY 1984 additional funds became available for IHAS services through the federal Emergency Jobs Bill. These Jobs Bill funds will reportedly enable SSA to increase the IHAS average monthly service levels. This increased service level is expected to be maintained through FY 1985 by Jobs Bill funds (which extend through December, 1984) and Social Service Block Grant carry-over funds.

Funds are allocated to the local DSS through a zero based budgeting process that allocates aide positions and purchase of service funds based on identified

need. Case managers, however, have not been allocated to local DSS through any formulated process.

Annual IHAS expenditures, as shown in Table 6, have declined 24% from FY 1981 to FY 1984. This decline is primarily attributable to reductions in federal funding. When inflation is considered these reductions become even more significant. We note, however, that the FY 1985 appropriation for IHAS services will be approximately 10% higher than the FY 1984 expenditure level.

Table 6

IHAS Program Expenditures
FY 1981 -1984

	Community Home Care (CHC)	Homemaker Service (HMS)	Federal Emergency Jobs Bill	Total
FY 1981	$3,541,031	$6,282,533	-	$9,823,564
FY 1982	3,213,826	4,364,514	-	7,578,340
FY 1983[1]	3,035,580	4,430,181	-	7,465,761
FY 1984[1]	3,054,899	4,037,934	$398,420[2]	7,491,253
Percent Change FY 1981 - 1984	-14%	-36%	-	-24%

[1]Projection based on year-to-date expenditure

[2]For purchase of service includes appropriations; for other items includes projected expenditures for 9/1/83 - 6/30/84.

Source: Social Services Administration

As might be expected these budget reductions have resulted in significant declines in the IHAS caseload which are reflected in Table 7. The percentage of aged clients being served, however, has remained fairly constant between 64% and 69% of total caseload. Clearly the majority of IHAS resources are being used to serve the elderly.

Table 7

Clients Served (Average Monthly Caseload)
In-Home Aide Services
FY 1981 - FY 1983

	Families and Non-Aged Clients*	Percent of Total	Aged Clients*	Percent of Total	Total	Percent Change in Total Caseload Over Prior Years
FY 1981	1,716	36%	3,090	64%	4,806	-
FY 1982	1,346	31%	2,974	69%	4,320	-10%
FY 1983	1,079	31%	2,414	69%	3,493	-19%
FY 1981 - FY 1983						-27%

* These categories are not mutually exclusive, hence there may be some persons over 65 who are in the "Families and Non-Aged Clients" category.

Source: Social Services Administration

D. Eligibility

To receive services from the IHAS program, a prospective client must meet financial eligibility requirements. Financial eligibility criteria are presented in Table 8 along with the range of fees charged for services.

Table 8

IHAS Financial Eligibility Requirements and Range of Fees

Gross Monthly Income	Percent of Median State Income	Fee Charged per Hour[1] Elderly (65+)	Non-Elderly
$ 0 - 949	0% to 80%	$ 0.00	$0.00
$ 950 - 1,365	80% to 115%	$ 1.00 - 2.50	$1.00 - 2.50
$ 1,366 - 1,884	115% to 150%	$ 2.50 - 9.00	Not eligible for services[2]
$1,885 and above	150% and above	$11.00	Not eligible for services[2]

[1]Based on a family unit of one, fees may be waived in protective service cases.

[2]Except for abuse, neglect or exploitation case in which services may be provided.

Source: In-Home Aide Services Fee Scale - July 1, 1983 - June 30, 1984

Authorizing legislation for CHC provides that "the community services under this program be available to all elderly persons, but those elderly persons who are financially able to do so shall pay all or a portion of the costs thereof." The CHC regulations specify that services shall be provided: (1) without cost to the elderly with incomes below 80% of the State median, (2) for a sliding scale fee to the elderly with incomes between 80% and 150% of the State median, and (3) for a full-service-cost fee to the elderly with incomes exceeding 150% of the State median. HMS regulations, on the other hand, specify that services will be

provided: (1) without cost to clients with incomes below 80% of the State median, and (2) for a sliding scale fee to clients with incomes between 80% and 115% of the State median. Clients with incomes exceeding 115% of the State median are generally not provided HMS services except in protective service cases. What has occurred in practice is that SSA has applied the more lenient CHC income eligibility standards to all clients age 65 or older, whether they are receiving services through the CHC or HMS program. It is for this reason that the IHAS fee structure for those 65 and older is different than for those under 65. This integration of program financial requirements is part of a larger effort to administratively merge and reorganize the CHC and HMS programs and other adult service programs in SSA as previously noted. COMAR regulations, however, do not accurately reflect current agency practices with respect to either financial eligibility or the fees to be assessed for services. It is recommended that the regulations be revised to reflect current practices and the reorganization in program structure and service delivery that has occurred.

E. Prioritizing Client and Service Availability

The IHAS program has generally had more requests for service than it can meet. In essence, demand for services appears to exceed the available supply. We note, however, that quantifying this demand is difficult because there are often no formal mechanisms such as waiting lists in local DSS offices to measure demand for services. Administrators have responded to the problem of excess demand for services in two ways. First, State SSA administrators, with local input, have developed a ranking scale that prioritizes clients according to need with considerable weight given to those most at risk of institutionalization. The scale also factors in degree of financial need. The scale is presently in a draft status pending comments from affected agencies. In the absence of a formal ranking system local DSS offices are, based on our review of eight offices, using

various means to prioritize clients including use of the draft ranking system, use of their own ranking methodology or, in the absence of any formal methodology, the judgment of staff. With the formal adoption and implementation of a ranking scale the prioritizing process will, of course, be standardized. We recommend that SSA proceed with this as quickly as possible. It is the ranking scale which will address the fundamental issue of who receives services and who does not.

The second response of local DSS administrators to the problem of excess demand for services has been to restrict the type of services available and dilute the intensity of services provided. Of those local DSS administrators interviewed, all have generally opted to serve as many clients as possible, without always providing the full amount or type of services that a client might require. For example, a client who might require aide visits five days a week may only get aide visits three days each week. This, of course, makes it possible to serve more clients but may not adequately provide the full quantity and type of service that a client may require. There is a basic policy issue here as to whether public resources should be focused on those few most at need or, conversely, whether an attempt should be made to only partially meet the needs of a larger group. Senior DHR and SSA administrators might wish to review how local DSS have addressed this important issue and, if necessary, provide some formal policy direction. We note that the local DSS practice of diluting services differs from the Gateway II approach which is basically to serve a few, ideally the most in need, adequately. This might also be a good issue for the IAC to review as it certainly has major implications for the elderly. It is recommended that DHR and the IAC consider further analysis on this issue and policy directives if deemed appropriate.

F. Services and Delivery Mechanisms

Services for the IHAS program are generally provided by DSS case managers and staff aides who are regular merit system State employees. Some services however are procured from vendors and private individuals.

The IHAS program has traditionally provided case management, personal care, homemaker/chore, heavy chore, transportation/escort services and, to an extent, respite care. Receiving increasing emphasis by SSA has been the use of "therapeutic aides." The purpose of the therapeutic aide program as noted previously, is to provide emotional support and guidance to clients who may abuse or neglect their children, adult dependents or themselves.

Therapeutic aides receive special training and are compensated one grade higher than other aides. They are, however, required to do "traditional" aide functions when necessary. For instance, in some neglectful situations, the service plan may also assign the aide to provide specific services (e.g., chore, personal care, etc.) for dependents until the caretaker begins providing the necessary care or the dependents are removed. There appears to be movement toward using aide positions for "therapeutic" functions and using purchase of service funds to buy the more traditional in- home service functions (e.g., chore and homemaker services) from private and non-profit vendors and individual providers.

1. Service Variability

In interviewing DSS staff in eight local offices, it became apparent that there is some variability from county to county in the types of in-home services offered. For example, some counties reportedly do not offer personal care services. One county supervisor indicated chore services were not provided unless other "socialization" needs were also present, although the operational definition of this term was somewhat vague. Both CHC and HMS regulations and

the IHAS manual (currently in draft form) specify the types of in-home services that may be offered but do not specifically mandate the range of services that must be provided. While we are sensitive to the need for local flexibility in defining and addressing service needs, we believe there may be merit in identifying a "core services component" for the IHAS program that each local DSS office must make available either through aides, purchase of service, or formal agreements with other agencies. This would: (1) close some of the service "gaps" identified through the Gateway II program (discussed later in this report), (2) help insure a reasonable degree of consistency between jurisdictions, and (3) help insure that all basic in-home services are available in each jurisdiction. We recommend, therefore, that DHR consider mandating, either through regulation or directive, that local DSS offices make available at a minimum, a "core" component of in-home services. Included among these services should be personal care, homemaker/chore services and perhaps respite care. It is our view that respite care could be part of a viable strategy to support and prolong the participation of families who wish to care for frail or disabled family members, but who do, on occasion, require some respite. Respite care may well be a service that warrants increasing emphasis.

2. Purchase of Services

With federal Emergency Jobs Bill funds, SSA has been able to expand its purchase of service programs and lessen its heavy dependence on using State merit system aide positions for in-home services. The SSA has permitted local DSS offices to use Jobs Bill funds for the purchase of chore and personal care services using both vendors and individual providers. This has enhanced local flexibility in responding to changing service needs.

SSA is in the process of evaluating the relative cost-benefit of using aides versus a purchase of service mechanism. Once accurate service cost data has been developed, this data should be compared with the program fee scale to see if the scale is appropriate, and accurately reflects program costs.

G. Case Management

Case management is an important service provided by SSA. Ideally comprehensive case management includes assessing client need, planning and developing a care plan, linking the client with available resources, client monitoring and advocacy. The SSA is currently engaged in training efforts to upgrade staffs' comprehensive case management skills. Emphasis is being placed on getting case managers to look beyond managing just those services provided by their specific agency and utilizing all public, private and family resources available.

In our view, case management for IHAS clients is important in that it provides on-going assessment and monitoring of clients and thus helps to insure that services provided are appropriate and responsive. SSA has mandated that all clients receiving CHC services shall have a case manager. Our interviews in eight jurisdictions indicate that only in one, Baltimore City, was there an inability to meet this requirement, although some counties state that they have substantially higher caseloads per case manager than is deemed advisable. Data from the Baltimore City In-Home Aide Services program indicates 86% of IHAS clients do not have case managers. The reasons for some jurisdictions being able to provide adequate case management services while others cannot are not entirely discernable but may well be related to the resource allocation process. At present, there is no formal methodology for allocating case manager positions to local Departments of Social Services. Additionally, it is not clear how case management positions are allocated among social service programs within local

DSS offices. SSA is reportedly going to begin a major study which will look at allocation of SSA resources to local departments in the near future. It is recommended that this study be structured so that it addresses the issue of allocation of case managers for in-home aide clients. We note that the FY 1985 appropriation has provided SSA with an additional 17 case managers. An appropriate allocation methodology would help assure optimal utilization of these positions.

IV. INTER-AGENCY COUNCIL ON AGING (OFFICE ON AGING): GATEWAY II PROGRAM

A. Overview

The Gateway II Program was established by Section 25, Article 70-B of the Annotated Code of Maryland during the 1982 Legislative Session.* This statute mandates that the program be administered by the Office on Aging, for the Inter-agency Council on Aging Services (IAC). (The IAC is a tripartite committee that includes the Secretaries of Department of Health and Mental Hygiene and Department of Human Resources and is chaired by the Director of the State Office on Aging.) Specifically the law established "a pilot program ... to provide services to frail or health impaired elderly persons at risk of institutionalization." Services to be provided are: "(1) integrated screening and evaluation; (2) development of an individual plan of care; (3) in-home services such as minor home repair, shopping assistance, homemaking, personal care, meal delivery or prepartion, supportive services to group or shared living arrangements, and health services; and (4) other community services such as day care, congregate meals, and other programs which may be of assistance to the elderly person or the adult care givers in maintaining the elderly."

To date, nine counties have been selected to participate in Gateway II. For a county to be eligible for participation in Gateway II they must develop "a community-based long-term care plan" which addresses various coordination and administrative issues. The following excerpt from the Gateway II Evaluation Report developed by the Office on Aging to evaluate the first year of program operation gives an overview of the program:

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* Gateway II should not be confused with the Gateway I program. The latter program is essentially an information and referral service operating in the local Area Agencies on Aging.

"Gateway II is a system for helping disabled elderly. It is the Geriatric Evaluation Services found in local Health Departments. It is the case managers in local Departments of Social Services. It is the coordinating and planning staff of the Area Agencies on Aging. Gateway II is an attempt to coordinate the three major long term care agencies at the local level to provide a formal system for a community care alternative to institutionalization. Gateway II provides a comprehensive assessment of an individual's problems and needs, a case manager to identify and secure all types of assistance which a client requires and a pool of funds to be used at a case manager's discretion when necessary services are not otherwise available."

The basic process for a Gateway II client, who is often initially screened and referred by the Gateway I program, begins with an assessment and evaluation, usually by the Geriatric Evaluation Service of the Aged and Chronically Ill Administration of DHMH. A care plan is then developed which addresses the client's needs and a case manager is assigned to provide comprehensive case management services. If those services which are required to maintain a client in the community are not available, "gap-filling" funds may be used to purchase those services. While this process is essentially the same for all Gateway II programs there are variations between jurisdictions. In their proposals for funding, each jurisdiction designated a lead agency (either DSS, DHMH or the local Area Agency on Aging) with operational responsibility for the program. The agencies which are to provide case management services, assessment and administrative support are also identified in the proposal. Only about 10% of Gateway II funds are used for administrative purposes (i.e., staff and overhead); approximately 90% of appropriated funds are used to purchase gap-filling services. This means that assessment and evaluation services, case management and administrative support functions are, to a large extent, donated on an in-kind basis by the three participating public agencies. This is discussed in more detail later in the report.

Table 9 provides a breakdown, by age and county, of clients served in the Gateway II program.

Table 9

Number of Gateway II Clients Served Since Start-up Through December, 1983
By County and Age

Months of Operation	14 Mos.	12 Mos.	14 Mos.	15 Mos.	5 Mos.	5 Mos.	3 Mos.	4 Mos.	
Total Number Served from Start-up through Dec.1983	Harford	Montgomery	Talbot	Wash.	Balto. City	Balto. County	Howard	Anne Arundel	Total
	120	110	235	75	369	139	37	33	1118
By: A. Age									
65 - 74	35	22	69	23	129	35	10	6	329
75 - 84	53	53	101	35	160	63	18	16	499
85-	32	35	65	17	80	41	9	11	290

Source: Gateway II Evaluation Report

It should be noted that of the 1,118 Gateway II clients, only 448 received "gap-filling" funds. Thus the majority of clients, 60%, receive only case management from the Gateway II program, with other services being provided to these clients through the regular public (e.g., SSA, DHMH, and AAA) and private service delivery systems. In reading the following narrative it is important to keep in mind the two distinct groups of Gateway II clients: (1) those who are case managed only and do not receive gap-filling funds and (2) those who receive both case management and gap-filling funds.

B. Eligibility for the Gateway II Program

The Gateway II program is designed for those who are 65 or older, moderately or severely disabled and at risk of institutionalization. Gap filling funds are further restricted to the frail elderly who:

1. need a specific service to be supported in the community, which is not otherwise available; and
2. are medically at risk of institutionalization (that is, are moderately or severely impaired according to their assessment); and
3. will be financially eligible for Medical Assistance nursing home coverage within six months of the identification of the specific service need.

Functional disability of Gateway II clients is measured using a case assessment instrument developed by the OoA. The Gateway II Evaluation Report indicates the functional disability of the 1,118 Gateway II clients surveyed as follows:

Table 10
Functional Disability of Gateway II Clients

Functional Disability	Number	Percent of Total
Severe	868	78 %
Moderate	227	20 %
Other	16	1 %
Data not Available	7	1 %
	1,118	100 %

Source: Gateway II Evaluation Report

According to a random sample of 177 Gateway II (case managed only and "gap-filling") clients, 93% were determined by the Delmarva Foundation* to be medically eligible for nursing home care using Medical Assistance "medical need" definitions. The level of care required by this sample of Gateway II clients is shown in Table 11. This data clearly suggests that the Gateway II Program is serving a functionally disabled population which is, in large part, eligible for nursing home care.

Table 11

Level of Care Determinations for a Sample of Gateway II Clients

Nursing Home Care Required Under Medicaid According to "Medical Need"	Number	Percent of Total
Not Eligible	13	7 %
Light Care	63	36 %
Moderate Care	80	45 %
Heavy Care	8	5 %
Heavy Special	13	7 %
Total	177	100 %

Source: Gateway II Evaluation Report

If a client receives only case management and no gap-filling funds there are no financial requirements. The use of "gap-filling" funds however, requires that financial eligibility be determined. To be financially eligible for gap-filling funds, the client must be: (1) financially eligible for Medical Assistance nursing home coverage within six months of the identification of the specific service need; and (2) "the public cost of the client's total individual package of services

* The Delmarva Foundation for Medical Care, Inc., is the Medical Assistance utilization control agent which is responsible for conducting level of care determinations.

per quarter, including gap-filling services, is not to exceed the average quarterly Medical Assistance cost of nursing homes in that subdivision." The nine jurisdictions with Gateway II programs have operationalized financial requirements in essentially nine different ways. The jurisdications vary in the way they consider assets (e.g., some have asset limits of varying amounts, others do not consider assets, while others consider assets in relation to income) and in their income limits. The result is that persons with the same income and assets may be eligible in one jurisdiction for gap filling funds, but not in another. Some variability is inevitable, of course, given the requirement that the cost of nursing home care in each subdivision be factored into the financial eligibility determinations. Nonetheless, in the interest of fairness and equity, it is recommended that the methodology for determining financial eligibility for the use of gap-filling funds be standardized, and a specific formula developed. Assets and income should be treated consistently throughout all jurisdictions. Simplicity, which appears to be lacking in some of the current methodologies, should likewise be a goal. Clearly any methodology developed should target those least able to pay for services.

Gateway II "gap-filling" funds appear to be serving the financially impoverished. The Gateway II Evaluation Report indicated about 18% of the program's total clients are Medical Assistance eligible. A review of the sample data on 89 gap-filling clients indicates that, with the exception of at most three clients, all would have been financially eligible for DSS IHAS services without having to pay a fee. Thus, the Gateway II gap-filling funds are being used to serve clients whose financial resources are similar to the DSS clients' resources (i.e., incomes less than 80% of the State median).

C. Funding History

Gateway II is completely funded with General Funds. The General Assembly first appropriated funds for Gateway II in FY 1983. After a competitive bid process four counties (Harford, Montgomery, Talbot and Washington) were awarded funds. In FY 1984 the program was expanded to Anne Arundel, Baltimore, Howard and Prince George's counties and Baltimore City. This expansion was accomplished primarily with unexpended funds from the four original Gateway II sites. The inability of the four original Gateway II counties to expend all of their first year funds was reportedly attributable to the start-up problems often associated with new programs. Table 12 presents funding history information in detail.

Table 12

Gateway II Program
Funds Awarded by Jurisdiction

Jurisdiction	Funds Awarded FY 1983	Funds Awarded FY 1984	Request** FY 1985
Harford	$ 90,000	$ 91,496	$ 91,496
Montgomery	120,000	120,000	120,000
Washington	55,800	60,954	60,954
Talbot	90,000	104,000	104,000
Baltimore County		100,000	100,000
Baltimore City		100,000	100,000
Anne Arundel		63,000 *	126,000
Howard		45,000 *	90,000
Prince George's		55,000 *	110,000
Total	$ 355,800	$739,450	$ 902,450

Note: Included in the Gateway appropriation but not reflected in the chart are funds for the Family Support Program which are $30,000 for FY 1983, $69,795 for FY 1984 and $49,000 for FY 1985.

* Partial Year of Funding funded with unexpended FY 1983 awards

** FY 1985 request is $875,781; chart includes $75,669 unexpended funds from prior years

Source: Office on Aging

The practice of the OoA has generally been to award Gateway II funds based on the amount of money being requested by each jurisdiction. Table 13 presents the percentage of the total of Gateway II funds allocated to each jurisdiction. Also presented is the percent of elderly (60+) and elderly poor in each of the Gateway II counties, which may be considered indicators of need. A comparison of these numbers would indicate that the current Gateway II funding practice may have led to certain anomalies and inequities.

Table 13
Gateway II Awards vs. Elderly and Elderly Poor
by Jurisdiction

Jurisdiction	Percent of Total Gateway II Funds Awarded[a]	Percent of Total Statewide Elderly (60+)[b]	Percent of Total Statewide Elderly Poor (60+)[c]
Anne Arundel	14	6.7	5.0
Baltimore County	11	17.9	9.7
Baltimore City	11	24.3	35.9
Harford	10	2.5	1.8
Howard	10	1.6	.8
Montgomery	13	13.2	4.8
Prince George's	12	9.9	5.6
Talbot	12	1.1	1.4
Washington	7	3.3	4.7

[a] Based on FY 1985 request

[b] U.S. Census Data, 1980

[c] Based on 1981 U.S. poverty level, from Survey of Income and Education, U.S. Bureau of Census, 1975

The above data suggests that some jurisdictions may be, relative to the other jurisdictions receiving funds, overfunded (e.g., Howard, Harford and Talbot counties) and some underfunded (e.g., Baltimore City, although the data does not reflect a federal grant for the Channeling program in the City). This assumes, of course, that the percentages of elderly and elderly poor are adequate indicators of the need for Gateway II services. A more structured and rational basis for

fund allocations, other than the present method of allocating funds solely on the basis of local requests, is needed. It is recommended that a formal mechanism be developed, subject to Executive and Legislative review, for the allocation of Gateway II funds. This mechanism should give considerable weight, to the extent that it can be measured, to the actual need of the disabled and poor elderly in each jurisdiction. Other factors, such as the administrative capacity of a jurisdiction to administer the program and the overall quality of the proposal should be considered, but given less weight than determinations as to actual need.

It is also recommended that the allocation methodology for Gateway II take into consideration DSS allocations for in-home aide services in each jurisdiction. As will be discussed in the next section of this report, most gap-filling funds are being used to purchase in-home services, similar to those provided through SSA, hence some coordination between OoA and SSA in allocating funds is essential. We do note that there is a requirement that gap-filling funds be coordinated with all other public funding at the local level. Major resource allocation decisions are however made at the State level and/or require State level approval. The IAC should review this issue as it clearly is an inter-agency funding issue that impacts on the elderly. Furthermore, it is imperative that a sound basis for fund allocations be established as soon as possible. Local jurisdictions tend to become dependent on given funding levels. Any abrupt changes in these funding levels can adversely impact services to clients and create difficult administrative problems.

D. Other Issues

As previously noted, the Office on Aging at the request of the General Assembly, completed an evaluation of the first year of the Gateway II Program. The report is extensive and no attempt will be made here to review all of its

findings. We have chosen instead to comment selectively on several findings that have implications which go beyond the Gateway II program.

1. Gap-filling Funds

As previously noted, all but 10% of Gateway II funds go directly for the purchase of "gap-filling" services. These gap-filling funds are to be used for the purchase of direct services that are not available through existing programs. These funds are not intended to supplant existing services but rather to supplement existing services and, in some instances, to create new services.

During the first year of Gateway II, 448 clients received gap-filling services. Table 14 provides data on the use of gap-filling dollars for the first year of the program.

Chore, heavy chore, personal care, personal care/chore and respite care are those services generally available through the In-Home Aide Services (IHAS) program of the Social Services Administration, with personal care and light housekeeping or chore services, as discussed in earlier chapters, generally provided through MMAPC for those persons who are Medical Assistance eligible. The data indicates in excess of 80% of the gap-filling funds were used to purchase services that are the mandated responsibility of SSA and/or the Medical Assistance Personal Care program. A more detailed analysis of the data indicates that local Departments of Social Services could not provide these services because: (1) the client needed more hours of service than the DSS could provide; and/or (2) service was not immediately available due to waiting lists. With respect to Medical Assistance eligible clients who received personal care purchased with gap-filling funds, we noted that the inability to locate a provider was often the reason the MAAPC program was not utilized.

Table 14
Amount of Gap-Filling Funds Expended for Purchase of Long-Term Care Services from Project Start-up through December, 1983, by County and Type of Service

Units of Service:	Harford	Montgomery	Talbot	Washington	Balto. City	Balto. County	Howard	Anne Arundel	Prince George's	Total
Chore Services	$ 6,297	$ 5,020	$ 27,010	$ 8,499	$ 558	$ 0	$ 0	$ 0	$ 0	$ 47,384
Day Care	0	1,608	0	0	0	765	1,760	0	0	4,133
Foster Care	0	976	0	3,548	150	0	0	0	0	4,674
Heavy Chore Services	0	0	559	1,173	0	0	0	0	0	1,732
Home Delivered Meals	0	0	17,803	0	0	0	0	0	0	17,803
Medications	5,119	0	32	546	0	311	0	0	0	6,008
Personal Care	8,228	5,047	29,484	4,927	4,991	0	3,063	4,446	0	60,186
Personal Care/Chore	0	35,902	0	0	9,996	751	0	0	0	46,649
Respite Care	12,407	0	842	3,658	585	360	0	0	0	17,852
Supplies	259	2,907	3,637	195	1,542	0	0	0	0	8,540
Transportation	0	50	5,014	827	1,704	0	0	0	0	7,595
Other	792	0	165	0	248	0	0	0	0	1,211
Cash to Families	0	7,709	28,898	10,634	0	0	0	42	0	47,283*
Total Net Gap-Filling Expenditures	$ 33,102	$ 59,219	$ 113,444	$ 34,007	$19,774	$ 2,187	$ 4,823	$ 4,488	$ 0	$ 271,050

* A statistically valid one month sample of gap-filling clients in Montgomery, Talbot and Washington counties indicates approximately 98% of the "cash to families" funds were used for chore, heavy chore, personal care, personal care/chore and respite services.

Source: State OoA, Project Gateway II, Evaluation of the First Year of Operation (1982-1983)

It is clear that the great majority of gap-filling dollars are being used to fill gaps in the In-Home Aide Service program of SSA. Put another way, had the IHAS program had greater resources, the large expenditure of Gateway II gap-filling funds for services normally provided by the IHAS program might not have been necessary. Similarly, had the Medical Assistance Personal Care program been more successful in recruiting and retaining providers, purchase of personal care services for a small group of Medical Assistance eligible clients may not have been necessary.

Gap-filling dollars not used for those services discussed above (i.e., Personal Care/Chore, Chore, Personal Care and Respite), have resulted in the creation of services not available prior to Gateway II. Examples of this would be home delivered meals in sections of Talbot County and the purchase of medicine and medical supplies for persons who are not eligible for Medical Assistance but are in some financial need.

The primary provider of gap-filling services in each of the four original Gateway II counties is, as expected, private vendors. The second most prevalent provider of services is the family. Of 89 persons included in the Gateway II gap-filling sample, 18 received family grants. The total expenditure of funds for cash to families is presented in Table 14. Family grants were used most frequently to purchase personal care and chore services. The Gateway Evaluation report summarizes the use of these funds thusly:

> "The counties took three approaches in issuing family grants. In Washington County, families were paid to provide the needed service. In Montgomery County, grants were issued through families, whereby the family secured services from another source. In most instances, these services were obtained from informal providers such as neighbors and friends. In Talbot County, a combination of the above described approaches was used... . Particularly in Washington County, it was noted that hiring family

> providers was the most cost-effective way of securing personal care and chore services since these providers were paid at a substantially lower rate than private agency providers. The County also cited the family's reliability and familiarity with client attitudes and needs as other beneficial reasons for hiring these providers."

Clearly a major strategy of the Gateway II programs is family grants. The MMAPC, IHAS and Attendant Care programs specifically prohibit the payment of public funds to family members. Payments to and through families to maintain a person in the community is a policy issue that would be appropriate for further analysis by the respective service delivery agencies, the IAC and the General Assembly in the interest of creating consistent State policy.

2. Clients Receiving Case Management Only

According to the Gateway II evaluation 670 clients, or 60% of the first year Gateway II caseload, received only case management services. These services were provided primarily on an in-kind basis by participant agency personnel. As discussed earlier, there are no financial eligibility requirements for these case management only clients. The Gateway II evaluation does not provide data on the service needs or financial status of these specific case managed only clients. (The evaluation does note the level of functional disability of the entire Gateway II caseload which includes both gap-filling and case managed only clients.) A better profile on this large client group would be useful in analyzing the impact of this program. It is recommended that data on the financial status and type and source of services being received by this case managed only group be collected by the OoA so that the following questions can be answered:

- Are the service needs and financial status of Gateway II case managed only clients such that they require case management services at public expense?

- By serving the Gateway II case managed only clients is the pool of persons eligible for public services expanding while at the same time the public service delivery agencies are not able to sufficiently case manage those clients that they are already mandated to serve under existing statute and regulations?

3. Donated or In-Kind Services

As noted earlier, only 10% of all Gateway II funds have been allocated for administrative costs. These administrative funds are generally used to fund only portions of positions, which is far less staff than is actually required for the Gateway II program given current caseloads. Limitations on the use of Gateway II funds for administrative costs was imposed by the Office on Aging to insure that most of the funds would be used for direct services. This means that assessment and evaluation services, case management, administrative support and program management functions are almost totally donated, i.e., provided on an in-kind basis, by the three participating public agencies, SSA, DHMH and AAA. SSA and DHMH are, of course, State agencies. AAA's are local agencies funded primarily through the federal Older Americans Act (OAA). (These latter funds are allocated by the Office on Aging based on the service plan submitted by each AAA.) Thus, the great majority of in-kind donations to the Gateway II program are funded from State agency appropriations. The Gateway II budget does not, therefore, reflect the true cost of the program. Our review of FY 1984 Gateway II proposals indicates in-kind contributions of $1.7 million. This figure does not include all of the in-kind contributions of services to clients or, in most counties, overhead, (e.g., rent, furniture, postage, etc.).

There are problems created by this heavy dependence on in-kind donation of resources. Specifically, this commitment may strain the resources of the service providing agencies. If we assume that the assessment staff, case managers, administrators, fiscal staff, nurses, etc., were fully utilized prior to

Gateway II and that the Gateway II program represents additional workload, then logically, some of the regularly assigned duties of donated staff cannot be performed as well as before. This may mean, for example, that services to some non-Gateway II clients (e.g., IHAS or DHMH clients) or the performance of non-Gateway II administrative functions will be adversely affected as a result of Gateway II. Assessing whether Gateway II represents additional clients who would not have been served in the absence of a Gateway II program is not easy. However, GES data does indicate increases in program growth since the inception of Gateway II that are greater in Gateway II counties than in non Gateway II counties. With respect to the IHAS program we note substantial reductions in caseload, due to budgetary reductions, at about the same time that Gateway II became operational. It could be argued that Gateway II, in large part, began to provide services to that population that would have been served by IHAS but were not because of budget reductions. In sum, while the data is not conclusive, it would not be improbable to assume that the Gateway II program does represent new and additional workload, and thus a strain on participating agencies. Adding some confirmation to this conclusion are the comments of some of the local counties. All four of the original Gateway II counties indicated inadequate funding for Gateway II case managers. Similarly, concerns about the administrative burdens imposed by Gateway II and the absence of Gateway II funded positions to handle these fiscal and program reporting requirements were noted during interviews. Harford County, in their FY 1984 application for Gateway II funds noted:

> "We did not budget for staff last year from Gateway II funds, and we are not doing so this year. This project, however, has required a great deal of staff time from the different agencies, and will continue to do so. As a result, Gateway II has put a great strain on our resources. We cannot continue to handle the workload generated by

> Gateway II and simultaneously meet the priorities of other programs. The implications of this squeeze on staff resources need to be considered at both the State and local level."

Montgomery County's survey response noted similar concerns in concluding that "the Gateway II Program is not staffed to provide case management to its caseload, nor is program administration adequately funded."

Another potential problem with in-kind contributions is that they may result in dual reporting responsibilities for those public agency staff donating time and services to Gateway II. For their Gateway II duties these staff report to the person(s) responsible for the Gateway II program; for their other duties they report to their respective agency supervisor. This type of arrangement can result in accountability problems for time and performance. We note however that every jurisdiction that participates in Gateway II is asked to coordinate efforts of contributing staff. This plan must be agreed to by all participant agencies and is designed to further inter-agency coordination.

In our view, it is problematic whether agencies, with increasing pressures to provide services despite declining or static public funding levels, will be willing and able to continue substantial uncompensated commitments of staff and other resources to the Gateway II program. We note, for example, that reductions in Older Americans Act funds to local Area Agencies on Agency and federal fund reductions to SSA have not been accompanied by concommitant decreases in requests for services. In sum, it may well be that use of in-kind services for major program functions may not be a viable long-term strategy. Put another way, programs have very real administrative and service costs that cannot be ignored.

4. Gateway II As a Means of Developing Systems of Long-Term Care

The State Office on Aging attempted to evaluate the "effectiveness of Gateway II in promoting the development of systems of long-term care." The major device used to assess Gateway II's effectiveness was a survey instrument that was completed by staff in the four original Gateway II counties. It is necessary as background, however, to understand what constitutes a community long-term care system. According to the Office on Aging, the following factors are identifiable as desirable characteristics of a long term care system:

a. Planning and development of a formal system should reflect participation by all three major public agencies: local health, social services and Older American Act recipient agencies, as well as the private sector.

b. The system should have a mechanism by which targeted clients are easily identified and brought into the system.

c. Those clients who are determined to be in need of long-term care should receive a comprehensive, multi-faceted, face-to-face assessment conducted in their usual place of residence. The assessment should address all areas of client health and needs: physical, social, psychological, environmental and financial.

d. Those clients who have a need for multiple services and are unable to arrange or maintain them in their own behalf should receive case management services.

e. Case Management should include: client advocacy, care planning, arrangement and securing of all needed services, client follow-up and ongoing monitoring, regularly scheduled and event-based reassessment and client tracking.

f. The system should collect and analyze data from the service area so that it is able to identify, quantify and plan for the needs of the disabled population.

g. The system should contain a mechanism which promotes the development and availability of needed long-term care services.

h. The system should contain mechanisms which promote efficiency and cost effectiveness.

With respect to Gateway II contributing to development of local long-term care systems, we have several comments. Survey responses in Harford, Talbot and Washington counties suggests that Gateway II has contributed to development of a long-term care system as defined above. In Montgomery County, there has been little or no change as a result of Gateway II. Based on our interviews, it appears that Montgomery County was moving toward a coordinated system of delivering services to the elderly long before Gateway II, hence the impact of the program in terms of systems development has been insignificant.

With respect to coordination, the Gateway II Evaluation report noted that all four counties reported that Gateway II systems approach has had a beneficial effect among the public agencies. We also note that three of the four counties have developed interagency committees to develop and implement Gateway II as well as carry out planning for the long-term care population. The effect of these bodies has been described as "variable" in each of the counties.. Montgomery County states it does not have such a body but notes there was already in place an interagency committee that performs similar functions.

The extent to which Gateway II has enhanced screening, assessment, and case manangement, which are key components of a long-term system is variable. Harford noted enhancements in screening, case management and assessment processes. Montgomery County noted some positive changes in the assessment/care management system while Washington County noted no changes in assessment or case management as the result of Gateway II. Talbot noted a more systematic approach to case management as a result of Gateway and improved reassessment procedures. All four counties, as previously noted, indicated problems created by lack of funds for case management.

5. Channeling Program in Baltimore City

Currently operating in Baltimore City is a federally funded national Long-Term Care Channeling project. This project is a research and demonstration project, funded by the federal Department of Health and Human Services, that evaluates a special approach to providing community based care for the elderly. The Channeling Program has received over $1.7 million since its inception in September, 1980. This federal funding is to expire in December, 1984, although the Office on Aging, which has operational oversight responsibility for this program, indicates that there are sufficient unexpended federal funds available to permit the program to continue operating until June, 1985. In FY 1984, and again in FY 1985, $100,000 in State Gateway II funds were awarded to Baltimore City for this program. These Gateway II funds flow through the federally funded administrative structure of the Channeling Program and are to be used for gap-filling services only. The Office on Aging indicates that funds will be requested for FY 1986 to convert the Channeling Program to a Gateway II model.

There are several significant differences between the Gateway II model and the Channeling program. First, the Channeling Program has its own assessment, case management and supervisory staff, all funded with federal funds, unlike Gateway II programs which in large part depend on in-kind donations of other agencies for these services. The director of the Channeling Program indicates that about $350,000 in administrative costs plus $100,000 for gap-filling funds would be necessary if the present Channeling staff complement and program is to be retained. This would permit the program to serve about 300 clients, not all of whom would require gap-filling funds. Without this $350,000 in administrative and case management funds, there would be no "program" unless the Channeling program converts to a Gateway II model (i.e., in-kind administrative structure). A second issue that needs to be addressed is the refocusing of the Channeling

Program toward: (1) improving inter-agency coordination in the City and (2) development of a comprehensive long-term care system. Based on our interviews it appears that the Channeling program is not working closely with the public agencies in Baltimore City in an effort to move toward development of a coordinated long-term care system. This is significantly different from the other Gateway II programs and must be addressed. We recommend that the State Office on Aging, in conjunction with appropriate local officials, develop a plan that addresses these differences, some of which relate directly to the use of in-kind staff discussed in the preceding section of this report.

6. Cost

The Office on Aging did an extensive cost analysis on Gateway II gap-filling clients. Using a random sample, which factors in all public cost (including in-kind) services, they conclude the following:

> On the average, community-based care for a Gateway II client costs the public $398 per person per month in local, state, and federal costs. If the same client entered a nursing home, his institutional care would cost the public $959 per month, on the average. The cost containment aspect of Gateway thus offers the dual potential of saving state dollars and saving local and federal dollars.

Table 15 displays this data in more detail.

Table 15

Comparison of Average Per Capita Costs for Publicly Funded Community Care and Publicly Funded Nursing Home Care for Gateway II Clients for October 1983 (N=89)

Average Monthly State Cost for Community Care (includes gap-filling costs)	$222
Average Monthly State Cost for Nursing Home Care	$482
Average Monthly Public Cost (State, Federal and Local) for Community Care	$398
Average Monthly Public Cost (State and Federal) for Nursing Home Care	$959

Source: Gateway II Evaluation Report

These cost savings are realized, of course, only if those gap-filling clients would have gone to a nursing home. As noted, 93% were medically eligible for nursing home care under Medical Assistance standards and all would have been financially eligible for Medical Assistance within six months of entering a nursing home. The Office on Aging staff asked case managers to identify how each of the 89 sample clients would have addressed their need in the absence of gap-filling dollars.

> "The response most often given was that the client would be institutionalized, 57% in nursing homes and 3% in hospitals. Of the 57% who would be placed in a nursing home, it was reported that 67% would be placed within three months. The other responses given were that the elderly individual: (1) would remain in his or her present home and let his or her need(s) go unaddressed 22%, (2) would remain in his or her present home and acquire assistance from family 14%, or (3) would leave present home and move in with family 4%."

We note that the Channeling program, which has a well designed research component, and utilizes a control group, should provide some interesting data on the relationship between community services and institutionalization.

7. Coordinated Services for the Elderly Project in Baltimore County

In 1979, the State Office on Aging received a five year $989,000 grant from the private Robert Wood Johnson foundation to develop a mechanism for coordinating services in both the public and private sectors for the health impaired elderly. Accordingly, Coordinated Services for the Elderly, Inc., (CSE) was established in Baltimore County with the Office on Aging and other service provider agency persons being placed on the Board of Directors. Basically, the CSE System is based on a case management model which places ultimate responsibility for assessment, service planning and monitoring of clients with a case manager. The project has developed: (1) standards for case management and (2) a sophisticated client tracking/case management automated information system. This automated system provides standardized assessment procedures for the impaired elderly, a complete client case record and a scheduled follow-up and reassessment process. All three public service providing agencies are part of the system, and are inputting and accessing data as necessary in Baltimore County. This system is also being used by the Baltimore County Gateway II program. This type of system is certainly consistent with the goals of the Gateway II program in that it enhances the concept of comprehensive case management and promotes interagency coordination and cooperation by improving the flow of client information between service providing agencies. Once this system is fully refined and evaluated it is recommended that the Office on Aging explore the feasability of transferring and implementing this system to other jurisdictions in the State.

V. STATE DEPARTMENT OF EDUCATION: ATTENDANT CARE PROGRAM

A. Overview

The Attendant Care program was established by the Education Article, Sections 21-501 through 21-506, Annotated Code of Maryland. It is a three year pilot program, begun in FY 1983, to provide financial assistance to eligible disabled adults for the purchase of attendant care services. The program is administered by one staff person* in the Division of Vocational Rehabilitation of the Maryland State Department of Education (MSDE) with assistance from a statutorily established Advisory Committee.** The Advisory Committee was created to provide guidance to MSDE in the development of rules and regulations, a sliding payment scale, and program progress reports.

Attendant Care services are essentially those services which are certified as necessary by a physician or registered nurse and are provided to an eligible disabled individual by an attendant. Services may include:dressing; preparing food and assisting the disabled person with eating; bathing and personal hygiene; assisting with routine body functions, including bowel or urinary care; moving into, out of, or turning in bed; laundering and providing other clothing care; house cleaning and other services of daily care, including shopping and transportation.

B. Eligibility

The Attendant Care program is currently providing assistance to 20 clients. To be eligible for financial assistance under the program an individual must:

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* Since the Attendant Care statute provides that no funds shall be used for administrative purposes if the program is administered by DVR (as opposed to contracted out), the responsibility for administering this program has been assumed by the Chief of the Technical Assistance Branch in DVR, as an add-on to her regular job duties.

** The ten member Attendant Care Advisory Committee includes representatives from the Maryland State Department of Education, Department of Health and Mental Hygiene, Department of Personnel, Governor's Committee on Employing the Handicapped, and the Developmental Disabilities Council. Two disabled individuals and two representatives of advocacy organizations for disabled individuals are also included on the Committee.

- be 18 to 64 years of age;
- have a severe chronic or permanent physical disability that precludes or significantly impairs the individual's independent performance of essential activities of daily living, self care, or mobility;
- meet income eligibility standards in accordance with the sliding payment scale; and
- not be receiving duplicate assistance from the Medical Assistance Personal Care program in DHMH or the Homemaker Chore or Adult Protective Service programs in SSA.

In addition to the above requirements, at least 50% of the individuals receiving financial assistance through the Attendant Care program must be: (1) gainfully employed, at least 20 hours per week, and receiving remuneration, or (2) actively seeking employment and be reasonably expected to become gainfully employed within six months. The other 50% of Attendant Care recipients must be: (1) residing in a nursing home, chronic or intermediate care facility and be capable of deinstitutionalization as a result of this program, or (2) on an approved waiting list of such an institution.

To participate in the Attendant Care program an individual must complete an application and a financial statement. They must also have their physician or a registered nurse complete a Standard Assessment of Functional Capability form developed by the department and the Advisiory Committee. These forms are then mailed to the Division of Vocational Rehabilitation in Baltimore where they are reviewed by the Program Coordinator. Approved individuals are sent an Attendant Care Agreement which must be signed by both the individual and the Program Coordinator. Eligibility for the Attendant Care program is reassessed annually.

Each client is responsible for selecting, hiring, training and supervising their own attendant. Family members cannot be employed as attendants. Clients must also maintain records of the hours and days of care provided, and pay their

attendants. A client is then reimbursed for all, or a portion, of these payments by submitting a bi-weekly payment request form to the Attendant Care program. The percentage of care cost reimbursement available depends upon a recipient's annual gross income and the number of persons dependent upon that income. Under the sliding payment scale developed by the Advisory Committee and shown in Table 16, clients are responsible for at least 5% of the cost of their attendant care services. However, co-payments can be waived by the Program Coordinator in exceptional cases where co-payment would result in financial hardship. The total amount of financial assistance available to any one client is $7,000 per year.

Table 16

Attendant Care Sliding Payment Scale

Annual Gross Income		Percent of Client Participation			
From	To	1*	2*	3*	4*
$ 0	7,999	5	5	5	5
8,000	8,999	5	5	5	5
9,000	9,999	10	5	5	5
10,000	10,999	15	10	5	5
11,000	11,999	20	15	10	5
12,000	12,999	25	20	15	10
13,000	13,999	30	25	20	15
14,000	14,999	35	30	25	20
15,000	15,999	40	35	30	25
16,000	16,999	45	40	35	30
17,000	17,999	50	45	40	35
18,000	18,999	55	50	45	40
19,000	19,999	60	55	50	45
20,000	20,999	65	60	55	50
21,000	21,999	70	65	60	55
22,000	22,999	75	70	65	60
23,000	23,999	80	75	70	65
24,000	24,999	85	80	75	70
25,000	25,999	90	85	80	75
26,000	26,999	95	90	85	80
27,000	27,999	100	95	90	85
28,000	28,999	100	100	95	90
29,000	29,999	100	100	100	95
30,000	30,999	100	100	100	100

* Number of persons dependent upon income.
Subtract 5 percent participation for each additional dependent over four persons.

Source: COMAR 13A.05.02.04K

C. Funding

The Attendant Care program's General Fund appropriation and expenditures for the first two fiscal years are shown in Table 17.

Table 17

Attendant Care Budget and Expenditures

Fiscal Year	Appropriation	Expenditure	Expenditure as Percent of Appropriation
1983	$150,000	$35,000 (actual)	23%
1984	$150,000	$90,000 (estimated)	60%
1985	$150,000	-	-

Source: Division of Vocational Rehabilitation, Maryland State Department of Education

As the above data indicates this program has been significantly under-expended since its inception. Initial year expenditures were significantly less than the budget appropriation due to delays in program start-up. The program did not begin providing financial reimbursements until February, 1983. Second year expenditures are expected to be only about 60% of the budget appropriation. This under-expenditure is also partially attributable to start-up delays. At the beginning of FY 1984, only eight clients were in reimbursement status. A second reason the program will probably be under-expended in FY 1984 is because even though there are currently 20 clients receiving reimbursements, the program is at least five or six clients short of a full caseload.

If each client received the maximum annual reimbursement of $7,000, the program would be able to serve only 21 persons, assuming full year participation by all clients. However, not all clients qualify for the maximum available reimbursement, and thus the program has potential to serve more than 21 clients. The best way to determine program service level capabilities at any given time, is to

monitor bi-weekly reimbursement rates. With an annual appropriation of $150,000, the Attendant Care program can maintain a bi-weekly reimbursement rate (i.e., a total bi-weekly pay out) of $5,769.* Current bi-weekly reimbursements total only $4,240, leaving sufficient funds for at least another five or six clients, and maybe more, depending on the particular reimbursement rates.

The Program Coordinator indicates that there is currently a waiting list of ten persons who are either in an institution or on an approved institutional waiting list, but that there has been some difficulty in obtaining counterbalancing clients in the employed-employable category.

D. Program Evaluation

As mandated by the enabling legislation, MSDE must submit annual reports on the Attendant Care program to the Legislative Policy Committee of the State Legislature by September 1, 1984, and September 1, 1985. The reports are to include demographic, disability, and cost effectiveness data, as well as recommendations regarding continuation of the program. With this in mind, no attempt has been made to evaluate the program. Instead, a brief overview of the client population currently receiving attendant care reimbursements is presented in Table 18 and is followed by discussion of some of the contrasts between Attendant Care and the MMAPC, IHAS and Gateway II programs.

* This is derived by dividing the total annual program budget into 26 equal bi-weekly reimbursement periods.

Table 18

Attendant Care Client Profile by Eligibility Status

	50% Employed-Employable Category	50% Institutional Oriented Category
Eligibility Status:		
Employed	8	-
Seeking employment	2	-
Institution resident	-	1
On institution waiting list	-	9
Age:		
18-29	4	2
30-39	3	1
40-49	1	3
50-59	2	3
60+	-	1
Disability:		
Multiple Sclerosis	1	6
Quadraplegic	5	2
Cerebral Palsy	3	-
Other	1	1
Service Arrangement:		
Individual provider	7	8
Private or non-profit vendor	1	2
Other	1	-
% of Cost Reimbursed:		
95%	5	7
90%	1	-
85%	-	1
80%	1	-
75%	1	-
45%	-	1
40%	1	-
20%	1	-
Financial Status:		
Medical Assistance eligible	-	3
IHAS eligible	8	6
Not eligible for MA or IHAS	2	1

Source: Division of Vocational Rehabilitation, State Department of Education

While the Attendant Care program makes available essentially the same type of in-home services available through the other three programs, there are four basic areas where the Attendant Care program strategies differ from those of the MMAPC, IHAS and Gateway II programs.

First, the Attendant Care program is a financial assistance program rather than a direct service delivery program. The MMAPC, IHAS and Gateway II programs provide direct services for their clients through a variety of service delivery mechanisms including the purchase of services from individual care providers and private agencies. In most cases, these programs serve as either the provider of services or the liaison or link-up between services and the client with program staff negotiating service contracts, paying for, and monitoring services provided. Attendant Care, on the other hand, merely reimburses the client for a portion of their cost of care. Clients are responsible for locating, initiating, overseeing and initially paying for their own care arrangements. This distinction has some interesting aspects. The Attendant Care system provides for maximum flexibility in service arrangements which is often a missing element in the staffed program approach (IHAS). The reimbursement approach, unlike the purchase of service approach, (MMAPC, IHAS, and Gateway II) has minimal administrative and oversight responsibilities. Additionally, since reimbursements are partial and capped, with the client absorbing the balance of service costs, there is an incentive for clients to select the most cost effective arrangement available.

Second, while each of the four programs included in this study were established to serve the chronically ill and disabled individuals who are at risk of institutionalization, the Attendant Care program appears to be focusing on a specific population that is somewhat distinct from the other three program populations. All but two of the current Attendant Care clients are chronically or

permanently disabled as a result of multiple sclerosis, cerebral palsy or quadraplegia. While persons with these types of disabilities are served through the MMAPC, IHAS and Gateway II programs, they are not the mainstay of these programs nor are they specifically targeted as such. It is not clear whether this population has been specifically targeted by the Attendant Care program or whether this particular population group has selectively sought assistance from Attendant Care rather than MMAPC, IHAS or Gateway II. It is also interesting to note that, unlike the other three programs, the Attendant Care client population is by and large not an aged one.

Third, the sliding payment scale developed for the Attendant Care program permits a significantly higher income eligibility standard than exists under the MMAPC or IHAS programs. An individual can qualify for Attendant Care reimbursements with a monthly income of up to $2,250, as compared to $267 for MMAPC and $1,884 for IHAS.* This higher income eligibility standard, in conjunction with the requirement that 50% of Attendant Care clients must be employed or seeking employment, offers an interesting strategy which is, again, different from the other three programs. This income-employment strategy allows individuals who are willing and able to work the freedom to earn an income and, in so doing, move toward economic self-reliance, without being penalized by the withdrawal of necessary services because their income becomes too high to qualify for traditional service programs (i.e., MMAPC or IHAS). However, we wish to note that of the 20 current Attendant Care clients, 17 are income eligible for either MMAPC or IHAS services.

A fourth point is the requirement that 50% of the Attendant Care clients must be either in an institution (at the time of application) or on an approved

* Although elderly persons (60+) can qualify for IHAS regardless of income.

waiting list for institutional care. This requirement insures that approximately half of the financial assistance available will be targeted toward a group of current institutional users and potential institutional users (i.e., those on an institutional waiting list), some of whom would otherwise probably be institutionalized at public expense. This targeting strategy has the potential to decrease the State's long-term care costs. Targeting this specific population of current and probable users of institutional care has not been done by the MMAPC, IHAS or Gateway II programs, as is discussed in detail later in this report.

We suggest that the Attendant Care Advisory Committee work closely with the IAC during the Attendant Care program evaluation process. It is recognized that the Attendant Care client population is generally not an aged population; however, the IAC agencies are familiar with other State initiatives that are similar to Attendant Care. It is imperative that the Attendant Care program be evaluated in context of these other State initiatives. In addition to the mandated review items required by statute (e.g., demographic, disability, and cost effectiveness data, as well as recommendations regarding continuation of the program), the Attendant Care evaluation should also specifically address such issues as:

1. Why there were difficulties in expending budgeted appropriations in FY 1984 (and if applicable, FY 1985). Is it because of insufficient demand for program services, inadequate program publicity, or requirements that are too restrictive (i.e., the 50% requirements)?
2. Why Attendant Care clients were not, or could not have been, served through MMAPC, IHAS or Gateway II, especially in view of

the new service flexibility available with IHAS purchase of service dollars.

3. Whether it would be more appropriate to have served the institutional oriented and perhaps the lower income employed and employable clients through the MMAPC, IHAS and Gateway II programs for which they do qualify, thereby freeing up more funds to assist the employed and employable population that is not income eligible for these other programs.

If the Attendant Care program is extended beyond the initial three years there are two issues that should be addressed. First, the program's target population should be more clearly defined vis-a-vis other service programs, i.e., MMAPC, IHAS and Gateway II. More specifically, is the Attendant Care program going to serve essentially the same type of clients served through MMAPC and IHAS but with more lenient income eligibility standards? If so, will there be overlaps among these programs? Or, conversely, is the program going to focus specifically on assisting a disabled/handicapped population in maintaining an economically independent or semi-independent life style? Second, should the program continue to be housed in MSDE or perhaps be transferred to another of the traditional service delivery agencies? The answer to this question will, of course, depend in large part to the answers to the above questions.

VI. OTHER ISSUES

During the course of this study, several issues arose which cut across program lines. These issues are discussed below.

A. Comparative Costs

There are several points we wish to note with respect to the comparative costs of the four programs discussed in this report. In this report we have, at a minimum, included data on total program costs and client usage for each of the four programs. More meaningful cost data that might, for instance, compare the cost of providing a unit of personal care services through each of the four programs is not possible given the current data base and the staff resources allocated to this project. There are, for example, differences in the way that units of service are defined and measured, widely varying service delivery mechanisms, and difficulties in accurately assessing indirect costs for each program.

In our view, the key cost question is not comparative program costs, but rather, which service delivery mechanism (i.e., purchase of service through vendors and individual providers or use of staff aides) is the most cost effective. As noted earlier in this report, SSA is currently engaged in a study to assess the relative cost benefit of a purchase of service approach versus the uses of staff aides. It might also be useful for the IAC, as a long range goal, to begin to develop the data base necessary to do meaningful cost analysis of providing services to the elderly. Such information would be useful in making decisions on budgetary allocations and help insure that funds are optimally utilized. Reportedly an ad hoc committee has been established by the IAC to develop an interagency data base.

B. Maximizing Federal Funds

During this study we identified two primary areas where federal funds can be more optimally utilized for in-home services. These two areas are: (1) use of

Older American Act Title III B funds and (2) serving Medical Assistance eligible personal care clients through the MMAPC program rather than through the IHAS program. As the discussion that follows indicates, the fiscal impact of this later item is relatively limited.

1. Use of Older Americans Act Funds for In-Home Services.

This study has focused on in-home services funded through four State agency programs. In-home services are also funded by several other private and public sources. One public source of funding for in-home services has been Title III B of the federal Older Americans Act. Under this Act, federal funds for the elderly are appropriated to the Office on Aging which in turn allocates these funds to 18 local Area Agencies on Aging (AAA's) based on a funding formula and a review of their annual plans.

In-home services are a mandated priority under the Older Americans Act. Under this statute, each agency must spend "some funds" from Title III B on in-home services. In-home services under federal law have a somewhat broader definition than the State's usual definition. In-home services, are defined in the Act as homemaker, home health aide, visiting, telephone reassurance and chore maintenance. The State OoA may elect to "waive the requirement" for expenditure of 'some funds' for in-home services if the Area Agency on Aging demonstrates that (in-home) services being furnished in the area are sufficient to meet the need for (in-home) services." Table 19 presents the Title III B funds allocated for in-home services by area agencies for FY 1981 and FY 1984. There are several significant points raised by this data.

- For FY 1984, seven jurisdictions had waivers granted by the OoA which released them from funding in-home services. This presumably means that these jurisdictions

Table 19

Use of Older Americans Act Title III B
Fund for In-Homes Services
FY 1981 and FY 1984

Area Agency	FY 1981 Funds Allocated for In-Home Services[2]	FY 1981 Percent of Total III B Funds Allocated for In-Home Services[2]	FY 1984 Funds Allocated for In-Home Services[2]	FY 1984 Percent of Total III B Funds Allocated for In-Home Services[2]
Anne Arundel[3]	0	0	0	0
Baltimore City[3]	155,259	9.2	26,132	2.2
Baltimore County[3]	32,030	5.3	0	0
Calvert	0	0	0	0
Carroll	7,168	7.0	16,101	18.0
Charles	3,200	8.7	2,796	5.7
Frederick	66,450	44.2	44,887	5.6
Harford[3]	1,200	1.3	0	0
Howard[3]	10,179	18.4	4,581	9.9
MAC (Lower Shore)	122,907	31.1	17,495	7.7
Montgomery[3]	0	0	0	0
Prince Georges[3]	69,000	15.5	33,500	10.8
St. Mary's	5,600	10.7	7,086	13.6
USA (upper shore)[3]	26,283	11.7	0	0
Western Maryland[1]	95,546	20.6		
Washington[3]	-	-	32,034	24.4
Garrett	-	-	11,414	21.8
Allegany	-	-	2,517	1.8
Queen Annes	-		0	0
Total	594,822	11%	198,543	5%

Note: Data was obtained for area agencies' plans and reflects proposed use and not actual expenditures

1. Western Maryland Area Agency was disbanded
2. Based on estimated FY 1981 actual expenditure of $5,289,916 and estimated FY 1984 appropriation of $3,664,645
3. Denotes Gateway II program in operation for FY 1984 (Talbot County only in MAC)

Source: Office on Aging

meet the federal requirement, in the opinion of the OoA, that in-home services in their jurisdiction were sufficient to meet the need. It is interesting to note that five of these jurisdictions have Gateway II programs and are using Gateway II General Fund gap-filling dollars to purchase in-home services because the local public agency service providers (e.g. DSS and DHMH) cannot adequately meet the needs of the elderly. This clearly raises questions about the standard OoA uses to grant in-home service funding waivers.

The total funds allocated to in-home services has dropped from $594,822 in FY 1981 to $198,543 in FY 1984. This represents a decline of 67%, yet during this same period Title III B funding declined only 31%. Stated another way, funding for in-home services as a percentage of total III B funds available has declined from 11% in FY 1981 to 5% in FY 1984. Clearly in-home services are receiving less priority from area agencies in FY 1984 than they did in FY 1981. One reason may be that the availability of General Funds for the purchase of in-home services through the Gateway II program is resulting in area agencies shifting their scarce federal dollars to other services. We note significant reductions in Title III B funding effort in several jurisdictions after the implementation of the Gateway II program. There certainly is no incentive for AAA's to fund in-home services if that service need is addressed through the

Gateway II program. Another possible reason for this diminution of effort may be that area agencies do not view the in-home services program for the frail elderly as important as some of their other programs.

The Office on Aging has recognized the need for a revised in-home services policy for area agency plans. They have developed more specific guidelines and procedures for the granting of waivers for the area agencies next fiscal year (FFY 1985). How this policy will be operationalized is unclear, but preliminary discussions suggest that some waivers will continue to be granted.

Ultimately the question to be answered is why both waivers and/or substantially reduced funding levels for in-home services are being granted or approved by OoA at the same time that the agency is requesting General Funds for the Gateway II program. These Gateway II funds are being used primarily for in-home services. Increasing federal III B funding for in-home services may diminish the need for General Funds for this purpose. It is our recommendation that the OoA policy on in-home services be reviewed once again by that agency and perhaps the IAC with a view toward a more stringent policy on area agency in-home services waivers and reductions of effort.

2. Coordination of MMAPC and IHAS Personal Care Services

As previously noted, both the IHAS program and the MMAPC program provide personal care services. Ideally the MMAPC program should provide personal care services to those who are Medical Assistance eligible (both financially and medically) and the IHAS program to those who are not Medical Assistance eligible. It is in the best interest of the State to maximize use of the MMAPC program for several reasons. First,

under the MMAPC program, 50% of all expenditures are reimbursed by the federal government and, as an entitlement program, there is no cap on total expenditures. The IHAS program, on the other hand, is a capped program funded with federal Social Services Block grant and General Funds. Second, the MMAPC program appears to be able to provide personal care services at less cost than the IHAS program. MMAPC uses, as noted, contractual care providers paid $10.00 per visit while IHAS primarily uses staff aides who are State employees with full benefits and who are reimbursed for all expenses. Third, referral of all Medical Assistance eligible personal care clients to the MMAPC program reduces demand on IHAS for services and allows SSA to focus resources on other non-Medical Assistance eligible clients, which ultimately provides the potential to serve more clients.

Assessing precisely how many Medical Assistance eligible clients are receiving personal care services from IHAS has proved a difficult task. Interviews with local DSS staff suggest an awareness of the MMAPC program and an indication that referrals to that program are being made, when appropriate. In order to further analyze this issue, a review of all IHAS clients receiving personal care services in Baltimore City was done by DSS staff. Of 263 personal care clients in the City, 73 were determined to be eligible for the MMAPC program. These clients represent approximately 5% of the total in-home services caseload in Baltimore City. Baltimore City does have a disproportionate share of the Medical Assistance eligible population and it would be inappropriate to draw conclusions about the magnitude of this problem Statewide based on the City data. Nonetheless, it is recommended that SSA issue a directive and implement appropriate procedures at local DSS offices to assure

proper coordinaton between the two programs. Additionally, periodic reviews of the IHAS caseloads to assess whether MMAPC eligible clients are receiving personal care service from IHAS is recommended. We note that Baltimore City DSS, as a result of this review, has developed revised intake and monitoring procedures to insure appropriate referral of Medical Assistance eligible personal clients to the MMAPC program.

C. Medical Assistance Home and Community Health Care Waiver

Under the current system, there are individuals who would qualify for Medical Assistance in an institutional setting, but who would not be eligible for Medical Assistance if residing in the community. It is estimated by DHMH staff that less than half of the Medical Assistance institutional population would retain their Medical Assistance eligibility status in a community setting. An example of how an individual may be eligible for Medical Assistance in an institution, but not in the community, is presented in Table 20.

The 1983 Session Joint Chairmens' Report directed DHMH to develop and implement a Maryland Medical Assistance Personal Care program for those persons needing long-term care who would be eligible for Medical Assistance in an institution, but not in the community, and who would be willing to remain in the community with the provision of personal care services. The intent was to extend MMAPC services to a group of people not currently eligible for those services, and thus provide them with a lower (public) cost alternative to institutional care. The Report also suggested that DHMH pursue a federal waiver so that Title XIX funds could be used to cover 50% of the cost of providing personal care to this group of persons. Since the Joint Chairmens' directive, DHMH has been reviewing the various options available under a waiver and a position

Table 20

Medical Assistance Eligibility
in Institutional and Community Settings

Institutional Setting			Community Setting	
Monthly Income:[1]	$	400.50	Monthly Income:[1]	$ 400.50
Personal Allowance:[a]		-25.50	Medical Assistance Eligibility Standard:[b]	-267.00
Liability Toward Institutional Costs:		375.00	Excess Resources:[c]	$ 133.50
Monthly Cost of Institutional Care:[2]		1,000.00		
Patient Payment Liability:		-375.00		
Medical Assistance Paid Balance:	$	625.00		

Assumptions:

1. This individual has a monthly income of $400.50 and $0 assets.
2. The Medical Assistance authorized monthly nursing home cost is $1,000.00

Notes:

[a]Institutionalized individuals are allowed to keep a personal needs allowance of (in this case) $25.50 each month.

[b] The Medical Assistance income eligibility standard for a single individual is $267 per month.

[c]Excess resources are those countable resources which exceed the "medically needy" resource level. An individual may be eligible for Medical Assistance if he qualifies under "spend down" provisions. "Spend down" eligibility is established when an individual incurs medical expenses equal to or greater than his excess resources. In this example, this individual must incur medical expenses of $133.50 before he becomes eligible for Medical Assistance in the community.

paper is expected to be issued sometime during 1984. Any implementation of waiver options, however, would not be likely before 1986. The narrative that follows presents a waiver overview and points out some issues that should be considered prior to processing an application for waiver.

Home and community health care waivers are authorized under the Omnibus Budget Reconciliation Act of 1981. The waiver allows Medical Assistance coverage for certain home and community health care services not previously covered and for certain persons not Medical Assistance eligible unless institutionalized. The waiver is a strategy to reduce Medical Assistance reimbursed long-term care costs, by encouraging lower cost home and community care alternatives to institutionalization.

Services available under a home and community care waiver include case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite, and other such services which offer a cost-effective alternative to institutional care. Home health aide, adult day care and personal care are already being offered, without waiver, under the Maryland Medical Assistance Plan. Personal care services are, of course, provided through the MMAPC program.

The waiver population is comprised of those individuals who would, in the absence of a waiver, require care in a nursing or skilled care facility, at Medical Assistance expense. The waiver allows a higher community income eligibility standard than currently exists,* includes a patient cost sharing feature,** and would not deem spousal or parental income.

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* The waiver income eligibility standard may be set as high as 300% of the SSI benefit level for an individual living in his own home, i.e., $913 per month for a single individual.

** Under this cost sharing feature, eligible recipients would be required to pay for all waiver services until they have reached the State subsistence level, i.e., the medically needy level.

Together, the higher income standard, cost-sharing and income deeming features operate to equalize the financial treatment of institutional and community based applicants.

While the home and community health care waiver appears to be an attractive cost saving measure, there are some difficult issues which must first be resolved and some fairly stringent constraints which will have to be adhered to should a waiver be implemented. For example, a waiver will not entitle Maryland to more Title XIX long-term care funding than would have been received in the absence of a waiver. The State must demonstrate in its waiver application that long-term care costs (both institutional and community) under a waiver will be equal to or less than they would have been in the absence of a waiver. Additionally, the State will be constrained from serving more people under a waiver than would have been served in the absence of a waiver. The State's past average growth rates in long-term care (both institutional and community) expenditures and number of recipients served would be used to project funding and service levels in the absence of a waiver.

Since the State will not be able to serve more people or spend additional dollars on long-term care services under a waiver, it becomes imperative that waiver services be targeted to those persons who would have been users of institutional care in the absence of a waiver. Indeed, the purpose of a waiver is to shift these would be institutional users to lower cost community care alternatives. This will, however, be extremely difficult to operationalize because true potential institutional service users do not necessarily equate to that group of persons who are certifiable for institutional care. In other words, there are individuals who are certifiable for Medical Assistance reimbursed institutional care

(although not eligible for Medical Assistance if residing in the community) but who, for a variety of reasons, would never have sought admission to a nursing or skilled care facility. These same individuals would be both medically and income eligible to apply for Medical Assistance community waiver services. In the absence of a waiver, this group of people would never have impacted upon the Medical Assistance long-term care system; however, with a waiver these persons would very likely become Medical Assistance long-term (community) care users. This factor is known as "latent demand." It is possible that implementation of a waiver would encourage an unknown quantity of new entries into the long-term care system (i.e., this "latent demand" group) who would never have had a public cost impact upon the long-term care system in the absence of a waiver, but would have a public cost impact under a waiver. This group would have to be screened out of any waiver program in order to insure that more people are not served under a waiver than would have been served in the absence of a waiver and that additional long-term care costs are not incurred. This will be extremely difficult to do with any degree of accuracy given the state-of-the-art in targeting true potential institutional users.

One way to insure that waiver client and cost constraints are not exceeded would be to implement a limited waiver that would restrict the availability of waiver services to a select number of eligibles. This would, however, not insure that clients served under the waiver are true "would be" institutional care users as opposed to "latent demand" users. One way to target would be institutional users is to focus on those persons who apply for a level of care determination from the State's utilization control

agent.* We note that neither MMAPC, IHAS nor Gateway II are attempting to work with this particular group of long-term care candidates. Each of these programs has a goal of preventing or delaying unnecessary or inappropriate institutionalization, yet they have not clearly focused on those at risk of immediate institutionalization. It can be argued that by the time an individual has decided to enter a nursing home, it is too late to interest them in community care alternatives. It can be further argued that these persons have so deteriorated by this time that it may be more cost effective to institutionalize them. The success of the Attendant Care program in working with this particular group of institutional oriented clients would suggest these assumptions may not always be true.

Cost savings to be realized through the rechanneling of true potential institutional care users into a more cost-effective personal care program are desirable. However, the home and comunity health care waiver should not be perceived as an immedicate panacea to the State's rising long-term care costs. Potential cost savings to be realized through implementation of a waiver must be carefully analyzed and should taken into consideration factors such as the following:

1. Can the same results be achieved without a waiver and its accompanying restrictions? The potential waiver population is already eligible for the IHAS, Gateway II, and Attendant Care programs. By

* The Delmarva Foundation is the State's utilization control agent. All applicants for Medical Assistance reimbursed nursing home care must first receive a level of care determination and certification from the utilization control agent. This includes nursing home applicants as well as nursing home residents who seek to convert from a paying status to a Medical Assistance reimbursed status.

targeting and giving highest priority to those individuals applying for a level of care determination, this potential waiver group could be provided a community alternative to institutionalization through existing programs. Since clients' needs can be addressed through existing State programs, cost/reimbursement considerations may therefore be the only reason for pursuing a waiver.

2. Can the potential financial benefits to be derived from a waiver be obtained without a waiver? By serving this client population under a MMAPC waiver rather than through IHAS or Gateway II, the State could realize potential savings in the form of:

a. Lower cost service delivery system, i.e., MMAPC service delivery being less costly than IHAS or Gateway II;

b. Client cost sharing; and

c. Federal (Title XIX) cost sharing.

We note that any potential cost savings to be realized through both a. and b. above could be achieved through modifications of existing programs. Specifically, the MMAPC service delivery mechanism could be adopted by the IHAS program or alternatively a State-only MMAPC (General Funded) program could be implemented. (Although it is important to note that as the demand for individual care providers increases, the State may find that it has to pay more than $10 per day to attract sufficient numbers of providers.) Client cost sharing could also be implemented in existing programs. This would effectively provide all of the potential financial benefits available under a MMAPC waiver, except for federal cost sharing, without resulting in any of the waiver restrictions or administrative burdens.

3. Are the financial implications of a waiver positive or negative? If the waiver program is not successful in targeting true would be

institutional users, additional public costs will be incurred for community based medical services. The individuals served under a waiver would be immediately eligible, without being required to spend-down, for Medical Assistance reimbursed medical care for all services available under the Maryland Medical Assistance Plan (MMAP)*. The cost of these services would represent a new demand on the Medical Assistance budget, and must carefully be considered in relation to potential savings to be realized as a result of serving clients under a waiver as opposed to through IHAS or Gateway II. We do recognize, however, that the Medicare program would be assuming a portion of the medical costs of those over the age of 65, however, since these individuals will now be Medical Assistance eligible, Medical Assistance would be required to pay the annual premium to enroll these individuals in the Medicare Part B program.

Additionally, it is conceivable that by requiring, under a MMAPC waiver, an individual of limited financial means to share in the cost of their waiver services, rather than serving them without charge through IHAS or Gateway II, the State may be impoverishing that individual to the point where it would not be financially feasible for them to continue residing in the community. This individual would then perhaps have to seek institutional care at public expense. In effect, a disincentive for remaining in the community may be created. This inadvertent upward pressure on demand for institutional services would seriously conflict with long-term care funding limitations imposed by the waiver and would, of course, be inconsistent with waiver and State policy objectives.

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* While these individuals would not be required to "spend down" for MMAP services, they would be required to share in the cost of their waiver services as noted earlier.

4. Responsibility for the potential waiver population currently rests with IHAS, Gateway II and Attendant Care. How will those "at risk" clients who are currently being served through these programs, but who meet waiver qualifications, be handled? Will they continue receiving services from existing program sources or be transferred to the MMAPC waiver program? What about future applicants who are eligible for each of these programs? Clearly close program coordination between the four service agencies will be essential.

The above discussions are not meant to discourage consideration of an MMAPC waiver program but rather to point out that there is indeed a myriad of complex issues which must be carefully addressed prior to applying for a personal care waiver. The intricacies of putting together a waiver plan that realistically achieves waiver objectives, without unduly restricting current program initiatives, are immense. It is possible that a personal care waiver program would not be as desirable an alternative for the State of Maryland as it would initially appear. Furthermore, it may very well be possible to achieve waiver objectives by carefully targeting existing service programs. It is recommended that prior to the submission of a waiver application, the IAC review the application. The client populations served by DHR and OoA are closely interweaved with the potential waiver population and possibly structural changes within the IHAS and Gateway II programs would be necessary if a waiver were implemented. The special expertise that each of these agencies has developed in community care services, should be of benefit to DHMH in reviewing the feasibility of a waiver.

D. Targeting Those "At Risk" of Institutionalization

We note that it appears to be an underlying assumption of all four programs discussed in this report that community-based services reduce the need for institutionalization. Indeed, community-based programs which target those "at risk" may reduce the incidence of institutionalization for their clients. However, the available data from these and other community programs is not conclusive as to the impact that community programs actually have on institutionalization rates. The effectiveness of community programs in reducing rates of institutionalization would appear to be dependent on the ability to target services not only to the eligible needy but, more importantly, to those eligible needy who would have actually been users of institutional care in the absence of community alternatives.

It may well be that community-based alternatives are beneficial in other ways (e.g., improved quality of care, increased longevity, etc.) that are more significant than their overall impact on institutionalization rates. However, we would suggest that more attention be given to focusing on that group of true would be users of institutional care. It is recommended that the IAC review current in-home service programs to assess whether resources are being focused on those most at risk of institutionalization. As noted earlier, neither the MMAPC, IHAS or Gateway II program is specifically focusing on those persons applying for a level of care determination from the State's utilization control agent. These persons indeed are truly "at risk" of institutionalization. A formal program that provides counseling and information to these applicants and their families on community-based alternatives to institutional care should be explored by the IAC.

E. Inter-agency Council on Aging Services (IAC)

There are, as has been noted, a number of different programs in several different agencies providing in-home services to the elderly and non-elderly. To view programs in isolation, without assessing their interrelationships and without benefit of system-wide comprehensive planning, needs assessment, and coordination can and does result in considerable and expensive inefficiency, service gaps and duplications. The IAC was established, at least in part, to develop the processes (e.g. planning, needs assessment, etc.) that result in a coordinated health and social services system for the elderly. Clearly there is much to be done if this ambitious goal is to be realized. We have identified several issues in this report that we believe the IAC should review. There are of course many others. To do the kind of planning and analysis required for these difficult tasks requires considerable staff time. Staff support for the IAC is provided by an Inter-agency Steering Committee chaired by the Director of the Long-Term Care unit of OoA. In our view administering the Gateway II program, which is an IAC project, has reduced the time that OoA's Long-Term Care unit has been able to devote to the many and complex problems facing the IAC. Refocusing some of this unit's resources from Gateway II to analysis of other key planning and funding issues might be appropriate and very beneficial to the services "system" over time. Some policy alternatives that would permit a refocusing of staff efforts are presented in the following chapter.

VII. POLICY ALTERNATIVES AND PROGRAM INTERRELATIONSHIPS

This chapter provides a systems view of the four in-home service programs and presents some policy options. Table 21 summarizes many of the key characteristics of the four programs and shows those areas where similarities exist. It is these areas of similarity (primarily clients served and services provided) which present opportunities for duplication.

With respect to the Attendant Care program, we note that it is in the second year of a three year pilot period. Any major restructuring of the program would be premature at this point. Outlined in Chapter V are a number of issues which should be addressed during the Attendant Care evaluation process. If this program is continued, it can be structured to serve a specific adult disabled population in a unique way, and thus not be duplicative of other State programs. This will require, as noted elsewhere, a more precise definition of the program's target population as well as closer coordination with the MMAPC and IHAS programs. This targeting, however, should not preclude consideration of transferring administrative responsibility for this program to one of the traditional in-home service delivery agencies. This is an issue which will require further analysis and should be considered during the evaluation process.

With respect to the MMAPC program, we note that when functioning as designed and if properly coordinated with the other in-home service programs, there need not be any duplications or service gaps. MMAPC should be the first alternative considered for those Medical Assistance eligibles who are in need of personal care services, with IHAS providing personal care only to those who are not eligible for MMAPC. With implementation of recommendations made elsewhere in this report, we do not see the need for any administrative restructuring of this program in relation to the other three programs.

Table 21
Comparison of In-Home Service Programs

	IHAS				
	MMAPC	CHC	HMS	GW II	AC
GOAL:					
To prevent inappropriate or unnecessary institutionalization.	x	x	x	x	x
To prevent or remedy neglect, abuse or exploitation of children or adults.	-	x	x	-	-
SERVICES PROVIDED:					
Case Management	x	x	x	x	-
Personal Care	x	x	x	x	x
Light Housekeeping	x	x	x	x	x
Heavy Chore	-	x	x	x	x
Shopping	x	x	x	x	x
Transportation/Escort	x	x	x	x	x
Parenting	-	-	x	-	-
Other*	-	-	-	x	-
CLIENTS:					
Income Eligibility:					
Medical Assistance Eligible[(a)]	x	x	x	x	x
Other[(b-e)]	-	x	x	x	x
Age:					
Children	x	-	x	-	-
18 - 64	x	-	x	-	x
65 and above	x	x	x	x	-
Characteristics:					
Frail Elderly	-	x	x	x	-
Chronically Ill or Disabled	x	x	x	x	x
Families in Need of Protective Services	-	x	x	-	-
SERVICE DELIVERY MECHANISM:					
Staff	-	x	x	x	-
Purchased from Vendors	-	x	-	x	x
Contractual Providers	x	x	x	-	-

* Primarily purchase of supplies such as diapers, orthopedic shoes, medicine, medical equipment and the like. Can include adult day care, meals on wheels and other such services.

NOTES: (All incomes shown are the maximum income level for a family of one.)

(a) Medical Assistance Eligibility
Categorically Needy - AFDC,SSI,GPA
Medically Needy - Assets: $2,500
Income: $267/mo.

(b) Community Home Care Eligibility
Assets: Not considered
Income: No limit.

(c) Homemaker Services Eligibility
Assets: Not considered
Income: $1,885/mo.

(d) Gateway II Eligibility
Eligible for medical assistance within six months of entering a nursing home.

(e) Attendant Care Eligibility
Assets: Not considered
Income: $26,999

With respect to the Medical Assistance waiver, we note that the issue requires further analysis by DHMH and the IAC. We caution against viewing the waiver as an immediate panacea to the State's long-term care needs, or more importantly, as a substitute program for the IHAS, Gateway II and Attendant Care program populations. In fact, given current federally imposed waiver requirements, it becomes problematic whether a waiver represents a realistic and cost-effective policy alternative.

With respect to the IHAS program we have provided several specific recommendations in Chapter III. With respect to IHAS services to the elderly we note the obvious and significant interrelationships with Gateway II. As noted in Table 21, both programs are providing many of the same services to much of the same elderly population. Indeed, the service needs and financial status of the elderly IHAS and Gateway II "gap-filling" clientele appear to be the same, as evidenced by services being requested and by financial profiles of Gateway II gap-filling clients.

Gateway II is described as promoting a "system" for the elderly that assures assessment, comprehensive case management, coordination of existing service programs, and finally some special gap-filling funds for services not otherwise available. Indeed, for the Gateway II case managed only clients (about 60% of the total caseload) the true impact of the program is difficult to determine. As noted earlier, we do not know much about this particular group of Gateway II clients. For instance, we do not know what their service needs are nor how their needs are being met, nor their financial status. However, for that 40% of Gateway II clients who are receiving gap-filling services, Gateway II appears to be functioning in large part as another service program. As noted earlier, in excess of 80% of the gap-filling funds are being used to purchase/provide services traditionally available through IHAS and to a less extent, MMAPC. In

effect, these gap-filling funds have been used to create an additional "program" of services for the frail elderly. A frail elderly person in a Gateway II jurisdiction can access services through the traditional service delivery programs (e.g., DHMH, SSA) or through the Gateway II "system" which, while often using the traditional service delivery agencies, is different. The Gateway II gap-filling system does provide a range, quantity and intensity of service that, for a variety of reasons, has not always been available through the traditional public service agency programs. It also treats all clients in a reasonably systematic and consistent manner in that all clients receive assessment, comprehensive care management and adequate services.

As discussed in detail in Chapter IV, the Gateway II program is not without problems. These problems stem in part from the fact that the Gateway II program depends heavily on the donation of staff from DHMH, SSA and local AAA's. This approach which is agreed to by all participating agencies and which may be enhancing interagency cooperation, appears to be straining the capabilities of participating agencies and thus, may have adverse service implications for non-Gateway II clients. Furthermore, the use of donated staff significantly understates the true cost of the Gateway II program. Because staff are donated (and often part-time) to the Gateway II program, they now have dual reporting and accountability responsibilities. In other words, not only are they responsible to their employing agency for that agency's clients, but they are also responsible to the local lead agency (and ultimately the OoA) for their Gateway II clients and funds. Also it is problematic whether agencies, with increasing pressures to provide services despite declining or static public funding levels, will be willing and able to make substantial uncompensated commitments of staff and resources to the Gateway II program. A Gateway II program which uses donated staff and other resources may not be a viable long-term strategy.

Gateway II has created an additional separate administrative structure complete with its own fiscal and program reporting requirements, its own State level administrative staff (in the OoA), and its own local program staff - albeit budgeted primarily in other agencies. Additionally, the respective missions of participating agencies and accountability for performance is somewhat obfuscated by this second system. Put simply the question becomes: Is the State going to concentrate resources in the traditional service delivery agencies (DHMH and SSA) and place responsibility for adequate in-home services to the elderly on those agencies? Or, conversely, will the State continue the practice of funding these same traditional in-home services (e.g., personal care, chore, etc.) through Gateway II as well? It could be argued that as long as Gateway II is given the resources to purchase traditional in-home services, there will be less money available and less incentive for the other service agencies to provide adequate in-home services for the elderly through their own programs. Indeed, if Gateway II is perceived as a provider of traditional in-home services, the "gaps" in existing agency service programs could grow.

A related issue that needs to be addressed is the most appropriate and productive role for the Office on Aging. Should it be to continue administration of a service delivery program or should it concentrate on planning, coordinating, advocacy and administration of the Older Americans Act? In sum, a policy issue to be addressed is whether the needs of the frail elderly at risk of institutionalization should be accomplished: (1) through a continuation of the present Gateway II program and its gap-filling mechanisms, (2) through revitalized and adequately funded programs in the established service provider agencies, or (3) some combination of the two.

Another policy issue that needs to be addressed is what level of service the State should be providing to clients with long-term care needs. As noted

elsewhere, Gateway II provides a level of service to clients that is greater than that provided to elderly IHAS clients. Whether the Gateway II approach is more effective than the IHAS approach in reducing or delaying institutionalization is unknown. The simple answer to how much service is "adequate" is that services should be sufficient to maintain those in the community who can reasonably be maintained in the community. Operationalizing this, however, is very difficult given the many variables that determine nursing home placements. Nonetheless, State policy makers must consider this issue in their deliberations on how the State is going to address long-term care needs.

It is our view that any administrative restructuring should, at a minimum, accomplish the following:

- Maximize the availability of needed services to that population most in need and at the lowest public cost;
- Provide a delivery system that is readily accessible to clients, is reasonably flexible in responding to client needs, is relatively simple to negotiate and well coordinated with other service providing agencies, and addresses client needs in a consistent, systematic manner;
- Minimize the service providers' administrative requirements and costs and fragmentation of the service delivery system.

Presented below are several policy options, including discussions of the respective advantages and disadvantages of each. These options consider, either implicitly or explicitly, the criteria and policy issues posed above. These options are not exhaustive but rather illustrative of different ways the interrelationships between the Gateway II concept and the traditional public agency service programs can be approached. It is important that the State continue with the

concept of developing coordinated long-term systems of care that treat clients in a consistent and comprehensive manner (i.e., assessment, evaluation, comprehensive case management and adequate services). Administratively this concept can be achieved in a number of different ways as the options presented below suggest.

Option 1-A: Gateway II Status Quo

This option would provide a continuation of the status quo, i.e., Gateway II as it now exists, in nine jurisdictions. This option would continue to provide some of the State's at risk frail elderly with adequate in-home services by providing assessment, evaluation, case management and, when necessary, gap-filling dollars for the purchase of services. The presence of the program may enhance inter-agency coordination, development of long-term care systems and perhaps the creation of new or additional services. This approach would continue the use of predominently in-kind staff for assessment, evaluation, case management and administration which, as noted before, could strain participating agencies' capabilities and have adverse implications for non-Gateway II clients. This approach would perpetuate the existence of a dual service delivery mechanism, which uses gap-filling dollars to purchase services that, in most instances, could be available through a properly funded IHAS program. Furthermore, it would continue the OoA in the direct administration of a State funded service delivery program and does not clearly delineate specific agency responsibilities with respect to providing in-home services for the elderly.

Option 1-B: Gateway II Expanded

Under this option Gateway II would expand to meet the total estimated need, not only within the current nine jurisdictions but in all 24 jurisdictions. According to 1983 OoA estimates, there are 29,411 people statewide likely to need Gateway II services of whom 4,412 would need gap-filling services. Gap-filling services could be provided by Gateway II, the other service delivery agences or some combination thereof. The total estimated cost of gap-fillng services would be, once again according to OoA, 11.3 million dollars. This latter figure does not include case management, administraive or overhead costs which would increase the total cost by a factor of 2 1/2 to 3.

The advantages of this option are essentially the same as described in Option 1-A with several modifications. Specifically, adequate services to more of the at risk frail elderly would be available statewide. What would ultimately develop is a very large statewide service program which would be providing traditional in-home services to a client group substantially larger than the current IHAS program population. The proposed strains on public agencies caused by in-kind staff donations would be so great with a program of this magnitude that funding of administrative costs would at some point be necessary. At a minimum, assessment and evaluation, case management, fiscal, clerical and supervisory staff would have to be funded along with related equipment and operating expenses. As in Option 1-A, this option would not provide a clear delineation of agency responsibility for providing in-home services to the elderly.

Option 2-A: Increased Funding of In-Home Services through SSA

Under this proposal the screening, assessment, case management, inter-agency coordination and systems development aspects of the Gateway II program would continue. The majority of gap-filling funds (at least 80% of which are now being used to purchase IHAS type services) would be appropriated to SSA for the IHAS programs. These funds could be specifically designated for services to the "at risk" elderly. A small amount of gap-filling funds could be appropriated through the Office on Aging to the Gateway II program for those items (e.g., special medical equipment, medication, special meal services, etc.) that cannot be addressed by other agencies. Additionally these funds could serve as an incentive for interagency cooperation and systems development. For this approach to work well the IHAS program must be adequately funded and have in place mechanisms that clearly give the frail elderly at risk of institutionalization priority for services. Also, the type and quantity of intensity of services provided must be adequate to address the needs of clients. These are all issues that can be readily monitored by the IAC.

This option begins the process of "filling the gaps" in IHAS services through the IHAS program. It also has SSA providing most of the services. It is this agency, of course, that has expertise and experience in providing services and already has the requisite administrative support systems in place that these programs require. This option would not preclude continued AAA involvement in providing in-home services. This option would reduce to a large extent the administrative workload of Gateway II in-kind staff as the amount of gap-filling funds is reduced. However, other in-kind staff requirements enumerated in Option 1-A

would continue as well as the problems associated with in-kind contributions. This alternative still continues the dual service mechanism created by Gateway II but decreases the dollars flowing through the "second" system. It continues the OoA in the role of administering a direct service program. However, it does begin to provide a clearer delineation of agency responsibility with respect to providing in-home services for the elderly.

Option 2-B: Total Funding through SSA

Under this proposal all funds for the frail elderly at risk of institutionalization would be appropriated to SSA. SSA would allocate the funds on the basis of need to local Departments of Social Services. Specifically identified in the budget would be funds for the frail elderly. Local DSS offices would be required to develop the necessary inter-agency agreements with DHMH, local AAA's and private vendors to insure that appropriate screening, evaluation, assessment, case management and in-home services are provided to the population in need. There should be sufficient flexibility with service funds so that they could be used for legitimate needs not heretofore available through IHAS such as special medical supplies and equipment, etc. Additionally a range, quantity and intensity of services would have to be available through IHAS to insure appropriate services. Services obtained from other agencies (e.g., GES evaluations, case management from local AAA's, etc.) would be funded on a reimbursable basis or, if private vendors are used, on a purchase of service basis. Local DSS offices should be required to develop local IAC's where they currently do not exist, that would include, at a minimum, all public service delivery agencies. These local IAC's should monitor this

program for the elderly, identify service gaps and duplications and move toward enhanced inter-agency coordination and comprehensive long-term care systems planning. The State IAC could continue to have responsibility for supervision of the program with DHR having the administrative responsibility. This would require a change in the law.

The advantages of this approach are: (1) concentration of resources for the elderly in the traditional service providing agencies; (2) elimination of a dual service delivery system (i.e., Gateway II) with retention of many of the positive aspects of that program; (3) elimination of the problems associated with substantial in-kind donations of resources; and (4) clearer delineation of agency responsibilities for services to the elderly and better accountability for performance.

Under this option, we would foresee a major role for OoA in monitoring this program to insure the needs of the elderly are met as well as providing technical assistance to local jurisdictions in the development of coordinated long-term care systems. By being removed from direct administration of the Gateway II program, the considerable resources of the OoA Long-Term Care Unit could be directed toward many of the complex problems faced by the IAC that were discussed throughout in this report.

A disadvantage to this approach is less local flexibility than is provided under the Gateway II program; SSA would be the "lead agency" in every jurisdiction. This approach would, however, allow the local DSS to "purchase" services from other public services agencies as appropriate.

In our view, one of the primary, if not publicly articulated, reasons for the creation of Gateway II was a perception that SSA could not

adequately serve a population at need because of under-funding and perhaps a certain bureaucratic rigidity in responding to the special needs of some clients. This approach challenges SSA and its local departments to provide creative comprehensive geriatric case management and to demonstrate flexibility in responding to the service needs of clients. With agency commitment and adequate resources, this can occur.

We note that all of the above options emphasize services to those over 65 and provide special services to the group. State policy makers have with passage of Gateway II and CHC programs indicated that they want programs which include age as a criteria. Clearly it is this group that requires the great majority of in-home resources. Nonetheless, there is a population under the age of 65 which is at risk of inappropriate institutionalization and in need of services. Social Services management indicates, for example, a growing need for services for disabled adults under 65. Development of a long-term care systems for all who require such services, regardless of age, is necessary. By working at systems development through SSA, lessons learned and systems developed can readily be transferred to or utilized by the non-aged population.